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The psychotherapy experiences, concerns and preferences of lesbians and gay men.

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THE PSYCHOTHERAPY EXPERIENCES, CONCERNS AND PREFERENCES OF LESBIANS AND GAY MEN

by

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B.Sc., University of Alberta, 1986
M.A., University of Windsor, 1990

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ABSTRACT

The purpose of the current study was to investigate the relationship between the mental health profession and the lesbian and gay community. One-hundred and twenty-three gay men and 65 lesbians completed surveys concerning their attitudes toward the mental health profession and their experiences with it. An experiment was conducted in order to examine the influence of a therapist's gender and expressed attitudes toward coming-out on the therapy experience of participants when the therapist's sexual orientation was unknown. Each participant read a description of a therapy situation in which the therapist's gender and attitudes toward coming-out (positive, neutral and negative) were manipulated. Evaluations of the therapist were measured on the Counselor Rating Form (Barak & LaCrosse, 1975), and the participants' comfort in discussing various personal issues were measured on the Counseling Concerns Scale (McDermott, Tyndall & Lichtenberg, 1989). The majority of participants reported some form of therapy experience but only 37.4% of participants with therapy experience reported working with a lesbian, gay or bisexual therapist. On average, participants reported a "moderate" level of satisfaction with heterosexual therapists or therapists with unknown sexual orientation. However, anecdotal reports by participants suggested a range of experiences from the overtly homophobic to positive and rewarding ones. Only lesbian participants reported significantly more satisfaction with lesbian, gay or bisexual therapists compared to heterosexual therapists or therapists with unknown sexual orientation. A therapist's gender was significantly more important to lesbian participants than a therapist's sexual orientation whereas sexual orientation was relatively more important to gay male participants than gender. Open-ended comments by participants suggested that a therapist's overall competence, experience and comfort with lesbians and gay men as well as similarity in cultural/racial background or sociopolitical views were at least as important as a therapist's gender or sexual

orientation. Results from the experiment suggested that gay male participants' evaluations of a therapist's attractiveness, expertness and trustworthiness and lesbian participants' evaluations of a therapist's expertness and trustworthiness were significantly influenced by attitudinal similarity. Moreover, gay males reported significantly less comfort in discussing issues central to their sexuality if they disagreed with the hypothetical therapist's views on coming-out whereas lesbian participants were significantly less comfortable in discussing issues that were both central and peripheral to their sexuality. The results are examined in reference to previous research findings. The contributions as well as limitations of the current study are discussed. Implications for the practice of psychotherapy with lesbians, gay men and bisexuals are provided as well as some considerations for future research.

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CHAPTER 1

INTRODUCTION

Homosexuality has never been embraced in our society even though it has existed in every race, class and culture throughout history. By the turn of this century, homosexuality had come to be viewed as a psychiatric illness after being condemned as a sin and illegal act for hundreds of years. Although the form of societal condemnation has changed through the years, it has always been homophobic and heterosexist in nature. Mental health professionals, being members of society in large, have tended to express similar negative attitudes. The purpose of the current study was to assess the relationship between the mental health profession and the lesbian, gay and bisexual community. In the current study, the experiences and preferences of lesbians, gay men and bisexuals in psychotherapy were measured as well as the effects of various factors associated with positive and negative therapy experiences. This introductory chapter provides an historical account of mental health professionals' attitudes and behaviour towards lesbians, gay men and bisexuals with a review of relevant empirical literature. The experiences of lesbians, gays and bisexuals as consumers of psychotherapy are discussed as well as the rationale for the current study.

Psychotherapist's Attitudes Towards Homosexuality

Historical Perspective. For the most part, treatment of lesbians, gay men and bisexuals by the mental health professions has reflected society's attitude that homosexuality is an abnormal condition that ought to be changed. Homophobic attitudes refer to the fear and hatred of gay people by family, friends and society and they operate at an individual and cultural level (Fassinger, 1994; Herek, 1984; Herek, 1991; Morin & Garfinkle, 1978). Social attitudes tend to be heterosexist as well. Examples of heterosexist bias include beliefs that

heterosexuality is superior to and/or more 'natural' than homosexuality and promoting heterosexuality while simultaneously discouraging gay, lesbian and bisexual lifestyles (Morin, 1977; Neisen 1990). Heterosexual bias is a more subtle form of societal censure than homophobia but is perhaps more corrosive and pervasive.

For hundreds of years, religious institutions defined and helped to maintain society's homophobic and heterosexist attitudes towards gay men, lesbians and bisexuals. At the turn of this century, the medical and scientific establishment began to invent theories to explain the causes and justify the "curing" of homosexuality. Although Freud subscribed to the popular nineteenth century notion of inherent bisexuality and was sympathetic towards homosexuals, he believed that it resulted from arrested psychosexual development (Hencken, 1982; Silverstein, 1991; Morgan & Nerison, 1993). Subsequent psychoanalytic theorists rejected Freud's ideas and developed a "phobic theory" of homosexuality in which homosexuals had an irrational fear of the opposite sex because of unresolved inner conflicts (e.g., Rado, 1940). Although the phobic theory has been challenged on empirical grounds, it still remains popular with the media and influential psychoanalysts such as Beiber, Dain, Dince, Drellich, Grand, Gundlach, Kremer, Rifkin, Wilbur and Beiber (1962), Socarides (1978), and Hatterer (1970). These psychoanalysts advocate intensive psychotherapy aimed at resolving the unconscious conflicts which result in the phobic reaction of homosexuality. Antigay sentiments have also been expressed by other schools of psychological theory and practice. For many decades, the behaviouristic school of psychology attempted to change homosexual behaviour by employing various classical and operant conditioning techniques that were often caustic (Morgan & Nerison, 1993; Silverstein, 1991).

In recent years, mental health practice and research with gay men, lesbians and bisexuals have undergone significant changes. Gonsiorek (1991) has argued that our

conceptualizations of the homosexual experience have finally begun to change after nearly 40 years of research. Today, homosexuality is understood as a complex phenomenon that is difficult to define and measure. Starting with the work of Evelyn Hooker in the 1950's, results of psychological testing have not supported the assumption that gays, lesbians and bisexuals are maladjusted. In the 1960's, serious questions began to be asked about the ethics and treatment outcomes in mental health professionals' attempts to "cure" homosexuality. Today, conversion therapies (both behavioural a d psychodynamic) are viewed as unethical and professionally irresponsible, as well as inadequate and questionable science (Haldeman, 1991). Thus, the old illness model of homosexuality has begun to crumble under the weight of empirical evidence and new lesbian and gay affirmative models have emerged to replace it (Gonsiorek, 1985; 1991).

In 1973, the American Psychiatric Association removed homosexuality from its official psychiatric nomenclature as a result of the growing empirical evidence, and pressure from the lesbian and gay political movement in collaboration with supportive mental health professionals. In response to the controversy and criticism, the American Psychiatric Association mailed ballots to every registered member and the resolution was upheld by 58% of those who responded (Bayer, 1981). Two years later, the American Psychological Association adopted the official policy statement that "homosexuality per se implies no impairment in judgment, stability, reliability or general social or vocational capabilities" (Conger, 1975, p. 633). This resolution urged all psychologists and mental health professionals to "take the lead in removing the stigma of mental illness that has long been associated with homosexual orientation" (Conger, 1975, p. 633). Similar policy changes were made by the Canadian Psychological Association in the same year. However, all of these progressive changes were made in the midst of great controversy (Morgan & Nerison, 1993).

Removing the psychiatric stigma of homosexuality in 1973 was a progressive move. However, the American Psychiatric Association was criticized for appearing inconsistent in their new enlightened approach towards lesbians, gays and bisexuals. For example, the retention of "ego-dystonic homosexuality" in DSM-II indicated that a homosexual orientation could still be considered a psychiatric disorder. After considerable debate, this psychiatric label was finally removed in the DSM-IIIR (1987) reflecting APA's continued acceptance of lesbians, gays and bisexuals (Bayer, 1981). This position, however, has been marred by recent empirical evidence which demonstrates that antigay sentiment continues to exist within the mental health professions (Garnets et al., 1991). Within psychology, for example, homophobic and heterosexist sentiment still exists in the clinical specialties (Garnets et al., 1991; Rudolph, 1989) as well as in general psychology (Buhrke, Ben-Ezra, Hurley & Ruprecht, 1992; Herek, Kimmel, Amaro & Melton, 1991; Morin, 1977) and it is possible to find homophobic rhetoric in published research that claims homosexuals are "more likely to commit child molestation" (Cameron, 1985; Cameron, Proctor, Coburn, & Forde, 1986), and that homosexual behaviour is "dangerous to society and incompatible with full health" (Cameron & Cameron, 1989). Cameron's publications are extreme examples of antigay prejudice which have not gone unnoticed by the American Psychological Association (APA). His membership with the APA has been revoked.

There are countless examples of how antigay bias may be manifested in individual psychotherapy (DeCrescenzo, 1984; Garnets et al., 1991; Gambrill, Stein & Brown, 1984; Gartrell, 1984; Hayes & Gelso, 1993; Riddle & Sang, 1978). Some therapists try "to help the client adjust to his [*sic*] condition", thereby implying that homosexuality is a condition similar to a chronic health impairment (Hayes & Gelso, 1993). Some therapists try to focus on a gay or lesbian client's heterosexual rather than homosexual relationships, thereby indicating the

greater importance and value of heterosexual relations. Some therapists view gay male or lesbian identity as a "phase" whereas others are preoccupied with the origins of a client's sexual orientation, thereby implying that something "went askew" Heterosexist bias may also operate when therapists work with same-sex couples. According to Elridge (1987) and Isay (1989), many heterosexual (and perhaps homosexual) therapists tend to use their preconceived notions of heterosexual relationships to assess, conceptualize, and treat same-sex couples. Some therapists may believe that same-sex relationships are unrewarding, potentially destructive, and of short duration, thereby reinforcing the societal notion that heterosexual life is intrinsically better, more stable, and conducive to growth. Some therapists may not appreciate the special benefits of same-sex relationships. For example, partners of the same gender probably enjoy a degree of compatibility and mutual understanding that is unusual in partners of opposite gender in the beginning stages of their relationships (Peplau & Gordon, 1982). Moreover, a greater emphasis is placed on emotional fidelity in homosexual relationships because there is no legal, social, or religious ties for same-sex couples (Isay, 1989). Finally, greater sexual flexibility and a greater capacity for changing roles exists within same-sex relationships for both gays and lesbians (Peplau & Gordon, 1982).

Heterosexual bias in psychotherapy is an ominous problem because it is often covert or overlooked. Rudolph (1989) suspected that psychotherapists acquire and communicate heterosexist sentiments to gay male, lesbian and bisexual clients without awareness because the process of acquiring prejudicial attitudes tends to be "infinitely subtle". According to this view, heterosexism is not experienced consciously because it is institutionalized and part of our culture. Thus, therapist's well-intended interventions may convey that they disapprove of homosexuality without their awareness. Such disapproval could be conveyed by the tone of their comments and the directions of their questions (Hayes & Gelso, 1993; Riddle & Sang,

1979). If clinicians do not monitor themselves when working with gay male and lesbian clients, then they are at risk of making inadequate conceptualizations, distorted clinical perceptions, and potentially harmful treatment interventions (Isay, 1989).

It took many years for mental health professions to acknowledge that homophobic and heterosexist attitudes and behaviour exists. The bold political move to eliminate homosexuality as a psychiatric condition in 1973 resulted in a proliferation of literature concerning the mental health professions' attitudes and treatment of lesbians, gays, and bisexuals. Research during the 1970's largely consisted of surveys but a few experimental investigations have been conducted since the early 1980's. An analysis of this literature follows.

Survey Research. Most surveys have focused on mental health professionals' attitudes toward the treatment of gay men, lesbians and bisexuals. Even though these results have been informative, most have suffered from methodological problems. For instance, the majority of surveys do not generally assess the impact of mental health professionals' own sexual orientation on their attitudes (Davison & Wilson, 1973; Fort, Steiner, & Conrad, 1971; Gartrell, Kramer, & Brodie, 1974; Graham, Rawlings, Halpern, & Hermes, 1983; Thompson & Fishburn, 1977). In other survey studies, lesbians are not differentiated from gay men (Fort et al., 1971; Davison & Wilson, 1973; Roman, Charles, & Karasu, 1978; Thompson & Fishburn, 1978). In addition, results are most often presented as percentages, making statistical comparisons difficult across studies. Finally, the representativeness of some survey samples is suspect because they are often small and restricted to single large American metropolitan areas such as Los Angeles or San Francisco.

Nevertheless, results of surveys indicate a wide variety of attitudes toward homosexuals and a number of inconsistencies. The results from early surveys did not reflect

the impact of the 1973 American Psychiatric Association's change in policy towards homosexuality. For instance, Fort et al. (1971) found that the majority of 163 mental health professionals surveyed did not believe that changing sexual orientation was a valid treatment goal *but* they believed it was possible. The majority (99%) agreed with the legalization of homosexuality but they also said that homosexuality could be categorized as a "personality disorder" or "sexual deviation" (73% and 83%, respectively). A survey of 86 behavioral therapists by Davison and Wilson (1973) also found both positive and negative attitudes. Even though the majority of therapists did not view homosexuality as a psychopathology (87%), gay men were characterized as being less good, less masculine and less rational than heterosexuals. In a survey of 412 psychiatrists' attitudes toward lesbianism, Gartrell et al. (1974) found that 98% favoured the legalization of lesbian behaviour but only 66% opposed the use of psychiatric labels in categorizing lesbian behaviour. Eighty-seven percent stated that their concept of mental health included the possibility of a well-adjusted lesbian but only 66% challenged the traditional belief that lesbianism represented a "sickness" or inadequacy. Finally, Roman et al. (1978) reported that 67% of 124 psychotherapists believed that a homosexual experience was acceptable for others but only 4% stated that a gay experience was acceptable for themselves.

Eleven years after the American Psychiatric Association's decision to de-pathologize homosexuality, Graham et al. (1984) surveyed 112 therapists' attitudes, knowledge, concerns and strategies in counselling lesbians and gay men. The results confirmed the researchers' suspicions that a diversity of attitudes towards lesbians and gay men still existed amongst psychotherapists. Although respondents showed generally liberal attitudes towards homosexuals (81% agreed with the current APA position on homosexuality), they admitted a lack of knowledge concerning gay and lesbian lifestyles. Sixty-two percent felt it was possible

for psychotherapy to change a person's sexual orientation and 37% said that they would "treat a homosexual with the direct aim of changing his/her sexual orientation". In order to educate and improve attitudes, Graham et al. (1984) recommended that training in counselling lesbians and gay men become a standard feature of accredited training programs and that competence in counselling gay clients become a prerequisite for state licensure.

Attitudes of graduate students and therapists-in-training towards gay men and lesbians have also been surveyed. Thompson and Fishburn (1977) conducted a survey of 42 female and 22 male graduate counselling students' attitudes toward homosexuality in terms of etiology, mental health, the role of the mental health profession, and the myths and fallacies surrounding it. Their findings indicated that female counselling students responded much more favourably than male students regarding many aspects of homosexuality. However, both men and women felt ill-prepared to deal with homosexuals, were unsure of its etiology and the role of the mental health profession. Ten years later, evidence for the continued need of specialized training was provided by Buhrke's (1989) survey of 213 female counselling psychology doctoral students. The survey's results indicated that female graduate students continued to receive little exposure to gay issues or clients and reported that they felt ill-prepared to work with gay people. In addition, McDermott and Stadler (1988) found that counselling trainees with minimal exposure to gay and lesbian people tend to have high levels of homophobia as measured by the Index of Homophobia (IHP) by Hudson and Ricketts (1980).

Rudolph (1988) reviewed all surveys and experimental studies of mental health professionals' attitudes toward gay men and lesbians conducted since 1970. He identified two types of inconsistencies in therapists' attitudes toward gay men and lesbians. First of all, he noted that the generally negative attitudes of psychotherapists' attitudes towards homosexuality

contrasts with more positive attitudes professed by their professional institutions. The second type of inconsistency is within psychotherapists themselves. According to Rudolph (1988), therapists are often of two minds when it comes to evaluating the acceptability of homosexuality. They tend to support a non-criminal attitude but not necessarily a non-pathological perception of homosexuality. In addition, counsellors tend to believe that a client's self-acceptance of homosexuality is necessary for psychological health but that a counsellor's personal acceptance of homosexuality is not.

The most extensive recent survey of psychologists' attitudes and treatment of lesbians and gay men was conducted in 1986 and published in 1991 by the American Psychological Association's Committee on Lesbian and Gay Concerns (Garnets et al., 1991). Over 2500 psychologists completed a questionnaire about their personal experience with, or knowledge of, biased and unbiased practice towards gay men and lesbians. A wide variety of attitudes and treatment of gay men and lesbians were reported with vivid quotes of both explicitly homophobic and subtle heterosexist attitudes and behaviours. Similar findings are reported elsewhere with mental health professionals from other disciplines. For example, many Canadian psychiatric faculty and residents in psychiatry and family medicine demonstrated various antigay attitudes and heterosexist treatment interventions in a survey by Chiamowitz (1991). Overall, the findings from recent surveys confirm the essential need for psychotherapists to educate themselves about homosexuality and to monitor their attitudes and behaviour toward gay male and lesbian clients.

Experimental Research. Over the past 15 years, a small number of experimental designs have been used to investigate mental health professionals' attitudes toward homosexuality. Once again, methodological problems abound. For example: 1) sample sizes tend to be small; 2) the representativeness of samples is often suspect; 3) a lack of agreement

in the definition and measurement of homophobia has resulted in the use of "home-brewed" attitudinal measures instead of standardized and empirically-based attitudinal measures; and 4) attitudes toward lesbians as well as bisexuals as distinct groups have been neglected just as they have been in surveys of attitudes.

Nevertheless, the results are somewhat useful and corroborate the survey results. The best known and most cited experimental study is by Garfinkle and Morin (1978). The researchers asked 40 male and 40 female psychotherapists to rate both a hypothetical client, based on a written intake case history, and a typical "psychologically healthy person" using a semantic differential scale. Subjects were assigned case histories in which the client was either heterosexual or homosexual, and male or female. The researchers found that attributions of psychological health differed as a function of sexual orientation of the client. Compared to a "psychologically healthy person", homosexuals were rated as more gentle, more quiet, more likely to express tender feelings, and more likely to possess a strong need for security. The authors concluded that the evaluations of psychological health were related to perceived violations of gender-role stereotypes. There were no differences in ratings of psychological health between lesbians and gay men. Attributions of psychological health differed as a function of the therapist's sex as well. Male therapists attributed less psychological health to all potential clients compared to female therapists. Male therapists also tended to equate psychological health with masculinity, a finding which replicates results reported by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970). In addition, male therapists were consistently more negative then female therapists in their attributions of psychological health to all homosexual clients. In particular, male therapists, as compared to female therapists, rated both lesbians and gay male clients as less masculine than the psychologically healthy person.

Garfinkle and Morin (1978) also reported interesting differences between the diagnoses, recommendations and treatment goals for heterosexual versus homosexual clients. Generally speaking, the results reflected a general belief that homosexual men and women were destined to have difficult lives due to the harsh treatment they were likely to receive within their culture. It appeared that the respondents lacked an awareness of the adaptive advantages of being gay and did not appreciate the potential for self-actualization.

The Garfinkle and Morin study has been venerated for many years and cited as validation that homophobia exists within the mental health professions. However, subsequent research utilizing the same semantic differential methodology has failed to generate similar findings. Glenn and Russell (1986) asked 36 female master's level counselling trainees to rate an audiotaped, role-played intake interview of an undergraduate female client whose sexual orientation was described as lesbian or heterosexual or was not identified. No significant between-group differences were observed in the ratings of psychological health. That is, the ratings of psychological health did not differ between heterosexual, lesbian or women with an unidentified sexual orientation. The findings from Glenn and Russell (1986) suggested that younger psychotherapists might not possess antigay sentiments. This warrants some close scrutiny since these results did not support those of Garfinkle and Morin (1978). The discrepant results probably reflect the numerous methodological differences between the two studies. For instance, Garfinkle and Morin (1978) presented their hypothetical clients in written vignettes whereas Glenn and Russell (1986) presented audiotaped interviews with hypothetical clients. Moreover, only young female clinical trainees participated in the 1986 study whereas older, more experienced clinicians of both sexes participated in the 1978 study. Finally, the younger clinical trainee's more positive attitudes could have been a reflection of changes in public attitudes toward homosexuality since 1978. Glenn and Russell (1986) said

that this made intuitive sense but they still observed heterosexual bias from the participants. Eighty-three percent of the participants assumed the partner in the ambiguous condition to be a member of the opposite sex.

Other experimental studies have identified stereotypic and/or negative attitudes towards homosexual persons amongst mental health professionals. Casas, Brady and Ponterotto (1983) found that stereotypes of homosexuality affected the accuracy of counsellors' cognitive processing of pertinent client information. In a more recent study by Crawford, Humfleet, Ribordy, Chu Ho, and Vickers (1991), 185 psychologists and social workers from 13 American cities read one of four vignettes describing a male patient who had AIDS or leukemia, and was homosexual or heterosexual. Their findings suggest that the participants consistently held negative and biased attitudes towards persons with AIDS. The patient with AIDS was reported as being more responsible for his illness, less deserving of sympathy, and more dangerous to the general public than a patient with leukemia. In addition, participants who held negative attitudes towards homosexual persons were less willing to have the gay male patient as a client regardless of whether he had AIDS or leukemia. As measured by the Index of Homophobia (Hudson & Ricketts, 1980), homophobic participants indicated that they felt uncomfortable working with the gay male client, were more likely to refer him out, and perceived their own issues about homosexuality as hampering their effectiveness. The authors concluded that bias and prejudice toward gay men and lesbians continue to exist in some parts of the mental health community.

Hayes and Gelso (1993) examined male counsellors' reactions to gay and human immunodeficiency virus infected (HIV positive) clients. Thirty-four male counsellors first completed a measure of homophobia (Homphobia Scale by Daly, 1990), then viewed a videotape of a role-played interview with a male client who was gay or heterosexual and HIV

negative or HIV positive. Counsellor discomfort was assessed by behavioural, emotional and cognitive measures which is an improvement upon previous empirical research which has only used attitudinal measures. As predicted, counsellors experienced greater discomfort with HIV-infected than HIV-negative clients. Client's sexual orientation did not affect the participants' discomfort but the participants' self-reported homophobia predicted their discomfort with the videotaped gay male client. Once again, these results suggest that counsellors need to pay attention to their attitudes and behaviour towards lesbian and gay male clients as well as people who are HIV positive.

Gelso, Fassinger, Gomez and Latts (1995) employed the same experimental design in examining male and female counselling students' countertransference reactions to a videotape of a lesbian discussing sexual difficulties within a relationship. Consistent with Hayes and Gelso (1993), the sexual orientation of the videotaped client did not significantly influence the graduate students' cognitive, affective or behavioural reactions. However, participants who reported relatively higher levels of homophobia tended to exhibit more avoidant responses toward the videotaped client when she was discussing her sexual difficulties. These findings replicated the results of Hayes and Gelso (1993) in their research on male counsellors' responses to gay male client actors.

To summarize, the cumulative results of experimental investigations conducted over the past 15 years suggest that psychological health judgements by therapists are influenced by a client's sexual orientation under some conditions (Garfinkle & Morin, 1978) but not others (Gelso et al., 1995; Glenn & Russell, 1986; Hayes & Gelso, 1993). A more consistent finding is that therapists' personal comfort with homosexuality can influence their work with gay men, a finding that underscores the need for therapists to be aware of their attitudes and behaviour toward gay male clients (Crawford et al., 1991; Hayes & Gelso, 1993).

Gay, Lesbian and Bisexual Experiences with Psychotherapy

To date, the majority of research in this area has focused on psychotherapists' attitudes and behaviour toward lesbian, gay men and bisexuals. For the most part, the homosexual experience in psychotherapy has been portrayed in personal accounts, case studies and books that provide assistance to psychotherapists who work with lesbians, gay men and bisexuals (Barrows & Halgin, 1988; Cabaj, 1988; Carl, 1990; Coleman, 1987; Gartrell, 1984; Gonsiorek, 1985; Isay, 1990; Jay & Young, 1977; Martin, 1982; Messing, Schoenberg & Stephens, 1984; Morin & Charles, 1983; Silverstein, 1991; Slater, 1988; Stein, 1988; Stein & Cohen, 1986). Limited attention, however, has been given to the actual experiences of lesbians, gay men and bisexuals in psychotherapy. In general, it has been reported that the gay, lesbian and bisexual community has not been satisfied with the services from the mental health community. Saghir and Robins (1973) reported that nearly one-third of the homosexual clients they interviewed had negative feelings about psychotherapy and they shared many examples of prejudice from their therapists. From 1977 to 1979, 48% of the gay, lesbian and bisexual people surveyed in Seattle indicated that they had some difficulty in finding "appropriate" counselling (Klein, 1986). In 1978, 71% of a large sample of lesbians and gay men in the San Francisco area (N = 394) reported serious difficulties in the use of heterosexual therapists (Gambrill et al., 1984). These concerns and fears were confirmed when most of a sample of heterosexual therapists did not know if they had any homosexual clients and/or did not perceive a need for specialized services for the gay community (Gambrill et al., 1984). In a review of the literature, Rudolph (1988) claimed that "up to 50% of gay clients have reported discontent with their professional counselling experiences" (p. 166). Recent research continues to demonstrate that college-aged lesbians, gay men and bisexuals are generally dissatisfied with general health and mental health services (Silker, 1994). It appears that lesbians and gay men still do not have access to,

or do not use, the same variety of mental health services as heterosexuals (Ussher, 1991). Families defined by gay or lesbian parents and same-sex couples are a "forgotten minority" in the mental health profession (Ussher, 1991).

The unique concerns and needs of lesbians, gay men and bisexuals for professional health care services have been recognized and addressed in recent years. From 1983 to 1988 in the United States, information relating to lesbians' experiences with the health care system was gathered with the National Lesbian Health Care Survey (Ryan & Bradford, 1993). The purpose of this comprehensive survey was to expand our knowledge about lesbians' experiences, needs and concerns. Seventy-three percent of the 1,925 respondents reported previous and/or current experience with professional counsellors whereas 36% had experience with non-professional sources of help such as peer-support groups and healing circles (Ryan & Bradford, 1993). The respondents to this survey also reported more concern with a counsellor's gender than a counsellor's sexual orientation or ethnicity. For example, 89% preferred to work with a female counsellor whereas only 66% declared a need for a lesbian or gay counsellor (Ryan & Bradford, 1993).

Over the years, it has been popular to speculate that lesbians, gay men and bisexuals might be better served by the mental health professional if they were to work with self-proclaimed gay or lesbian therapists. In fact, this belief that special groups of people would be best served by therapists who share their special group membership has been popular since the early 1970's (Atkinson & Schein, 1986; McDermott, Tyndall & Lichtenberg, 1989). However, there has been relatively little empirical evidence to support the idea that homosexual therapists are more credible sources of help to homosexual clients than heterosexual therapists. Liljestrand, Gerling and Saliba (1978) found that similarity in sexual orientation between a client and therapist was related to positive psychotherapeutic outcomes. Based on interviews

with 36 lesbians, Wandrei found that lesbian clients felt more favourable toward their psychotherapy if they had a lesbian therapist (results of an 1975 honours thesis by Wandrei, cited in Liljestrand et al., 1978).

A recent survey by Moss (1995) explored the experiences of lesbians, gay males and bisexuals in therapy and their perceptions of heterosexual bias. Only a minority of the respondents reported experiences with a lesbian, gay male or bisexual therapist (23% of 112 lesbians, 73 gay men and 28 bisexuals) whereas 54% had worked with a heterosexual therapist and 22% were unaware of their therapist's sexual orientation. Respondents who reported antigay bias perceived their therapists to be less knowledgeable about lesbian, gay and bisexual issues. Significantly more heterosexual bias was reported when the therapist was heterosexual or the therapists' sexual orientation was not known. The respondents who experienced more bias were also less likely to focus on a variety of issues related to sexual orientation and less likely to seek help for relationship difficulties. It is interesting to note that the respondents were more likely to know the sexual orientation of their therapists from elsewhere (that is, the therapists did not disclose their sexual orientation directly to their clients). Moss (1995) concluded that lesbians, gay men and bisexuals are less likely to perceive their therapists as being biased when they know their therapists' sexual orientation, regardless if it is heterosexual, lesbian, gay or bisexual. Moreover, lesbians, gay men and bisexuals assume that a therapist is heterosexual unless they are told otherwise. Therefore, therapists who do not disclose their sexual orientation put themselves at risk of being perceived as homophobic and heterosexist which has negative consequences for lesbians, gay men and bisexuals (Moss, 1995).

To date, there have been only two experimental studies investigating the effects of sexual orientation similarity between a therapist and client. Atkinson, Brady and Casas (1981)

investigated the importance of similarities in sexual orientation and attitudes between gay male clients and their male therapists. Eighty-four gay men (aged 17 - 66 years), identified as holding either an activist or non-activist stance on gay advocacy, rated a therapist's expertness, trustworthiness and attractiveness on the Counselor Rating Form after listening to an audiotaped segment of an interview between a male therapist and a male client expressing sexual orientation concerns. When the therapist stated a preference for men, he was rated as more expert, trustworthy and attractive compared to counsellors who stated a preference for women or refrained from stating a sexual orientation. Attractiveness ratings were also found to be a function of attitude similarity between the audiotaped counsellor and the study's participants. The researchers concluded that a male therapist's sexual orientation is important for a gay male client's psychotherapeutic experience. Moran (1992) investigated the effects of sexual orientation similarity between a therapist and client as well as a therapist's experience level on lesbian and gay males' evaluations of a therapist. After receiving pre-session information in which the variables of therapist sexual orientation (gay male/lesbian or heterosexual) and experience level (experienced or inexperienced) were manipulated, 40 gay male and 40 lesbian participants viewed different 15-minute videotapes of same-sex therapist-client pairs discussing depression and existential concerns. Based on ratings on the Counselor Rating Form, lesbian participants rated the experienced therapists as more expert. The therapist's sexual orientation did not appear to have any significant influence on the ratings by gay male or lesbian participants. Therefore, Moran concluded that a therapist's sexual orientation may be a less salient concern for gay men and lesbians when the therapeutic issue is not sexual in nature.

The psychotherapy preferences of lesbians and gay men have been measured as well. In a survey by McDermott et al. (1989), nearly half (49%) of 83 lesbians and gay men (aged

16 - 68 years) preferred either a gay or lesbian psychotherapist. Some male respondents also reported that they would feel uncomfortable in discussing sexual identity issues with certain psychotherapists. As measured by the Index of Homophobia (Hudson & Ricketts, 1980), the more homophobic the gay male respondents were, the less comfortable they tended to be in discussing concerns related to their sexual identity with a therapist whose sexual orientation was unknown. The researcher concluded that lesbian and gay men prefer working with gay or lesbian therapists. However, a surprising 39% of the participants reported that the therapist's sexual orientation did not matter. The authors feared that this was a potentially dangerous position since recent empirical evidence suggests that a number of therapists continue to harbour antigay sentiment (Garnets et al., 1991; Graham et al., 1987; Rudolph, 1988).

Individual psychotherapy, however, is not the only form of professional mental health assistance which gays, lesbians and bisexuals utilize. Group psychotherapy, family therapy and couples counselling are other modalities that lesbians and gay men can utilize, especially if they are struggling with relationship problems. Modricin and Wyers (1990) assessed that attitudes of same-sex couples toward the mental health profession by asking 128 gay and lesbian couples about the quality of their relationships and their help-seeking behaviours. Communication, sexual and separation difficulties were most often cited as reasons for seeking professional assistance. In addition, 40% of the gay male couples were unwilling to seek help compared to 14% of the lesbian couples. The authors argued that this probably reflects ancient gender-role prescriptions of how men and women are supposed to cope with personal problems. Finally, the results suggested that the therapist's sexual orientation did not matter to couples seeking counselling whereas gender did.

Critical Analysis of Lesbian and Gay Research

In general, the focus of research on lesbians, gay men and bisexuals has changed dramatically over the past 20 years. Before 1975, research focused on diagnostic issues or finding the causes of homosexuality (Morin, 1977). Today, psychologists are constructing a lesbian and gay male affirmative psychotherapy (Morin & Charles, 1983) and research typically focuses on the quality of life for lesbians, gay men and bisexuals (Gonsiorek, 1985; 1991). These are progressive changes in lesbian and gay research; however, it is still developing and needs improvement.

Buhrke et al. (1992) examined research on lesbian and gay male issues in counselling journals over a 12-year period. Only 43 of 6,661 (0.65%) studies focused on variables related to gay or lesbian issues (Buhrke et al., 1992). The content of articles demonstrated a general acceptance or affirmation of gay men and lesbians. However, numerous limitations of the research were evident. For example, the vast majority of published articles are surveys that report only descriptive statistics. Buhrke et al. (1992) suggested that more experimental research is needed in order to systematically increase our knowledge of the lesbian and gay experience. Burhke et al. (1992) were also concerned about the lack of theory guiding gay and lesbian research and suggested that researchers familiarize themselves with some of the well-established theories developed for understanding the experience of other oppressed minority groups (e.g., racial/ethnic groups). Specific methodological criticisms about gay and lesbian research have also been discussed by Buhrke et al. (1992), Rothblum (1994) and Rudolph (1988). Many gay and lesbian studies have used small samples thereby limiting the ability to generalize the results to the whole lesbian, gay and bisexual community. A concerted effort by researchers is needed to increase the diversity of samples as well as their size because the majority of the studies have consisted of highly educated, middle-class

Caucasians who are members of community organizations or groups (Buhrke et al., 1992; Rothblum, 1994). Finally, researchers have tended to disregard the inherent differences between gay men, lesbians and bisexuals by failing to study them separately. Until recently, lesbian and gay research has been criticised as being androcentric in that the number of published studies focusing on men have outnumbered ones focusing on women by margin of 4:1 (Sang, 1989).

Our knowledge of the lesbian, gay and bisexual experience can also be improved by developing and encouraging alternative research methodologies. According to Sang (1989), the current movement away from existing theoretical models should continue because traditional theories tend to be heterosexist and sexist. Innovative and creative research methods are being developed resulting in an increasing number of qualitative studies that are descriptive, narrative and phenomenological in nature. Lesbians are also coming to know themselves through oral histories, biographies, consciousness-raising groups and grass-roots publications (Sang, 1989). As a result, there has been a breakdown between the traditional roles of researchers and participants and research topics are becoming more relevant to everyday lesbian, gay and bisexual people. Such exciting changes in scientific inquiry will inevitably help everyone to learn more about themselves.

The ground-breaking policy resolution by the American Psychological Association in 1975 urged all mental health professionals to "take the lead in removing the stigma of mental illness that has long been associated with homosexual orientation" (Conger,1975, p. 633). However, Walsh-Bowers and Parlour (1992) question whether recent gay and lesbian research have contributed to the emancipation of lesbians, gay men and bisexuals. Walsh-Bowers and Parlour reviewed 351 articles involving homosexuality from 1974 to 1988 and found that authors rarely involved participants beyond the role of providing data. Most of the studies did

not report conditions of consent nor did they provide feedback or inform the participants that the findings were going to be used to promote social action (Walsh-Bowers & Parlour, 1992). Male researchers have also tended to study men exclusively whereas female researchers have tended to work with both genders. Based on the results of their literature review, Walsh-Bower and Parlour (1992) argue that research with gay men, lesbians and bisexuals should foster their emancipation and not "detract" from it. Emancipation can be fostered if researchers refuse to use the traditional paradigm of "detached, value-free inquiry" when studying oppressed groups because researchers themselves might unwittingly reinforce social oppression (Minton, 1986). Researchers should strive towards an "emancipatory social psychology". This involves establishing democratized relationships between researchers and participants, making a serious commitment to social action, involving participants in all aspects or phases of scientific inquiry from "conception to authorship" and developing writing styles that are more humanized and non-hierarchial (Walsh-Bower & Parlour, 1992).

Rationale for the Current Study

The primary purpose of the current study was to gain a better appreciation for the relationship between the lesbian, gay and bisexual community and the mental health profession. The study was designed to incorporate theoretical and methodological improvements suggested by previous researchers. Both survey and experimental approaches were used in the current study. Survey research over the past 25 years has focused solely on therapists' attitudes and behaviour toward gays, lesbians and bisexuals. However, therapists' self-reports are only half of the picture. Therefore, this study attempted to focus on the experiences, concerns, preferences, and feelings of lesbians, gay men and bisexuals toward the mental health profession. An attempt was made to include qualitative methods in order to

allow lesbians, gay men and bisexuals to express their experiences in their own words in addition to a traditional survey that produced quantitative data.

The cumulative results of surveys conducted over the past 25 years have established the fact that homophobic and heterosexist attitudes exist within the mental health profession. Therefore, it was also necessary to move beyond the exploratory level of survey research and use a more complex experimental design to determine which factors are associated with the experience of antigay sentiment by lesbians, gay men and bisexuals. Some factors that influence the psychotherapy experience of lesbians and gay men have already been identified by two previous experiments. Atkinson et al. (1981) demonstrated that gay males' made more favourable evaluations of a gay male therapist compared to a heterosexual one. However, subsequent research has failed to demonstrated the importance of a therapist's sexual orientation. Moran (1992) demonstrated that lesbians' evaluations of a therapist were influenced by a female therapist's experience level but not her sexual orientation whereas gay males' evaluations of a male therapist were not influenced by the therapist's sexual orientation or experience level. There are probably countless other factors that influence the psychotherapy experience of gay men, lesbians and bisexuals. The two factors investigated in this experiment were a therapist's gender and disclosure of his or her views on lesbian and gay issues.

The importance of a therapist's gender has been extensively researched over the past 30 years. Generally speaking, the conclusions from the vast array of research over the years have reflected changing societal attitudes towards gender roles. In the 1960's and 1970's research usually found a preference for male therapists because participants expected male therapists to be more knowledgeable, more competent, more experienced and better adjusted (Boulware & Homes, 1970; Fuller, 1964). It was popular to speculate that males were better

therapists for work-related difficulties whereas females were better therapists for emotional difficulties and interpersonal problems (Yanico & Hardin, 1985). However, recent research has found that women are now requesting to work with female therapists and refusing to work with male therapists, if given the choice (Walker & Stake, 1978; Stamler, Christiansen, Staley & Macagno-Shang, 1991). In fact, there are an increasing number of studies indicating preferences for female therapists by everyone, and for stereotypic feminine characteristics in therapists, regardless of gender (Atkinson & Schein, 1986; Stricker & Shafran 1981).

Atkinson and Schein (1986) have argued that a positive therapeutic outcome is a function of similarities between a client and therapist. Based on Strong's (1968) social influence model of counselling, therapists must be perceived as being credible if they are going to help clients change their attitudes. Atkinson and Schein (1986) claim that one way to ensure this perception of a therapist's credibility is to make a client aware of the similarities between the client and therapist. In a review of the research investigating the importance of similarities between therapist and clients, Atkinson and Schein (1986) concluded that attitudinal similarity may be more important than similarities in group membership (i.e., gender, racial identity, ethnic background). Therefore, a lesbian, gay male or bisexual client's therapy experience may be more positive if a therapist discloses attitudes, opinions and ideas about gay and lesbian issues that are similar to the client's. This claim is supported by one experimental study in which gay male participants gave more favourable ratings of a male therapist who expressed similar attitudes on gay advocacy (Atkinson et al., 1981).

The process of a therapist disclosing personal information as well as sharing his or her views on various social issues has been a controversial topic in psychotherapy since its inception. Historically, therapist self-disclosure was regarded as countertransference in psychoanlysis. A therapist was trained to be a neutral, non-intrusive observer in order to allow

the client to project unconscious fantasies and fears onto the therapist. The development of transference was dependent on the client's lack of knowledge about the therapist's personal life, feelings or thoughts (Kooden, 1991; Stricker, 1991; Wells, 1994). During the past 30 years, the growth of humanistic psychology has sparked interest in the potential therapeutic benefits of therapist self-disclosure. Client-centred, experiential and process-oriented therapies hold that it is the therapeutic relationship that is the "agent of change" as opposed to any therapeutic technique. The therapist has to be genuine, transparent and congruent (Rogers, 1961) as well as willing to disclose significant information about him/herself when appropriate (Carkuff, 1969). This marked a departure from the traditional psychoanalytic view that a therapist had to operate as a "blank slate" (Wells, 1994).

The effects of therapist self-disclosure are multifaceted. A therapist who appropriately discloses personal information helps to promote a client's own self-disclosure which in turn strengthens the therapeutic relationship (Derlaga et al, 1990; Palambo, 1987). It has also been argued that therapist self-disclosure is a useful intervention with more poorly integrated clients who benefit from experiencing the therapist as a whole and distinct person (Weiner, 1983; Wells, 1994). Therapist self-disclosure has also been theorized to be useful when a client is from a minority group that has been historically oppressed, stigmatized and disadvantaged whereas the therapist is not (Jenkins, 1991). According to Jenkins (1991), minority clients tend to be more aware of and sensitive to the inequities in the relationship between a therapist and client. They actively test their therapists in early sessions and will not proceed until they are satisfied that they will be treated with understanding, respect and dignity. As a result, therapist self-disclosure may be a method of assuring that the climate in the therapy room is more receptive than it is in the dominant society. Therefore, self-disclosure by a therapist encourages self-disclosure by a client which stimulates the growth of the therapeutic

relationship (Jenkins, 1991; Stricker, 1991).

In the current study, it was hypothesized that the psychotherapy experience of lesbians, gay men and bisexuals would be influenced by a therapist's gender. It was hypothesized that lesbians, gay men and bisexuals would respond more favourably to female than male therapists when they did not know the therapist's sexual orientation. In particular, it was hypothesized that therapists would be evaluated more favourably if they were women and that lesbians, gay men and bisexuals would feel more comfortable in discussing personal issues with female therapists.

It was also hypothesized that many lesbian, gay male and bisexual participants would respond favourably to a therapist who disclosed "gay positive" attitudes and negatively to one who expressed homophobic and heterosexist attitudes. However, not everyone shares the same attitudes towards various social issues. A therapist's negative attitudes may not necessarily antagonize all lesbians, gay males and bisexuals. There are many lesbians, gay men and bisexuals who harbour internalized homophobic attitudes and some lesbians, gay men and bisexuals unwittingly subscribe to mainstream heterosexist views. Therefore, it was hypothesized that attitudinal similarity between a therapist and client would be related to a positive therapy experience, regardless if the attitudes were positive or negative. In particular, it was hypothesized that therapists would be evaluated more favourably if they expressed attitudes towards lesbian/gay issues that were similar in nature to lesbian, gay male and bisexual clients. Moreover, lesbians, gay men and bisexuals would feel relatively more comfortable in discussing personal issues with therapists who expressed similar views on lesbian/gay issues.

It was also proposed that certain background characteristics of lesbians, gay men and bisexuals would account for some of the variability in how they experienced therapy. Previous

experience with psychotherapy and personal comfort with one's own sexual orientation were two such background characteristics.

In addition to investigating the influence of a therapist's gender and attitudinal similarity on the experience of lesbians, gay men and bisexuals in therapy, the current study attempted to assess their satisfaction with previous and/or current psychotherapy as well as their preferences in choosing a therapist. These experiences and preferences were measured in a traditional survey utilizing ratings scales as well as open-ended questions. The rationale for utilizing both quantitative and qualitative methods was to optimise the chance of obtaining a comprehensive picture of this complex issue.

CHAPTER II

METHOD

Participants

The participants were 65 lesbians, 123 gay men, 18 bisexual women and seven bisexual men (N = 213) with ages ranging from 19 to 80 (M = 33.81, SD = 11.45). There were no significant group differences in age. Participants were recruited from a number of different organizations such as campus groups, social clubs, musical performance groups, and church congregations. Participants also responded to advertisements in gay-related newsletters and posters in community centres as well as Internet listings (2 gay/lesbian/bisexual-related and 1 women's issues). All of the participants were self-identified gay men, lesbians, bisexual women or men. There were no selection criteria other than the participants had to be at least 19 years of age. The majority of participants were from metropolitan Detroit and southwestern Ontario. However, participants recruited via Internet were from various areas in the United States and Canada. A total of 430 questionnaires were distributed producing a participation rate of 49.5%.

Table 1 provides the number of participants who were recruited from various settings. Results from non-parametric analyses suggested that there were significant group differences between participants who were recruited from different settings, X^2 (8, N = 206) = 62.22, $p < .0000$. There were no significant group differences in student status or cultural/ethnic background. Less than half of the participants were full-time students whereas the majority of them reported a Caucasian/European ethnic background (47% and 89%, respectively). See Appendix A for the ethnic backgrounds of all participants. Significant group differences in citizenship were observed, X^2 (2, N = 206) = 8.11, $p < .05$. Only 49.2% of the lesbian participants were U.S. citizens whereas 64.2% of the gay male and

Table 1

Recruitment Settings for Participants by Sexual Orientation

	Lesbians (N=65)		Gay Men (N=123)		Bisexual Women (N=18)		Bisexual Men (N=7)	
Settings	#	%	#	%	#	%	#	%
Campus groups	7	10.8	47	38.2	1	5.6	0	
Community groups	1	1.5	18	14.6	0		2	28.6
Church groups	21	32.3	21	17.1	1	5.6	0	
Internet advertisements	20	30.8	29	23.6	15	83.3	5	71.4
Newsletter advertisements	16	24.6	8	6.5	1	5.6	0	

83.3% of the bisexual female participants were from the United States. Table 2 contains information regarding the participants' education, income and occupation. Results from non-parametric analyses did not indicate any significant group differences in education, income or occupation. The data from the bisexual female and bisexual male participants were not included in any further data analyses because of the small sample size and questionnable representativeness.

Research Design

A survey was designed to investigate the therapy experiences of lesbians, gay men and bisexuals as well as their attitudes, feelings and preferences in choosing a therapist. Quantitative methods were employed in order to generate data that could be compared to previous research. Qualitative methods were also used in order to allow participants to express their experiences, preferences and concerns in their own words. Within the survey, an experiment was also designed to measure the extent to which a therapist's gender and expressed attitudes toward coming-out would influence the experience of lesbians, gay men and bisexuals in a hypothetical therapy situation. The experiment had a completely randomized 2 (therapist gender) X 3 (therapist's expressed attitude) factorial design. Each participant read a description of a therapy situation in which the therapist's gender and expressed attitudes toward coming-out (positive, neutral and negative) were manipulated. The dependent measures were ratings of comfort in discussing personal issues and evaluations of the therapist's attractiveness, expertness and trustworthiness.

Materials

Therapy Vignette. The therapy vignette required the participants to imagine

Table 2

Participant Demographics

	Lesbians (N=65)		Gay Men (N=123)	
	#	%	#	%
Education				
partial high school	1	1.5	3	2.4
high school	14	21.5	43	35.0
college diploma	10	15.4	5	4.1
undergraduate degree	24	36.9	42	34.1
graduate/professional degree	16	24.6	30	24.4
Income				
under $10 000	26	40.0	37	30.1
10 000 to 30 000	21	32.3	41	33.3
30 000 to 60 000	16	24.6	37	30.1
over 60 000	2	3.1	8	6.5
Occupation				
non-working student/unemployed	21	32.3	29	23.6
skilled labour	4	6.2	14	11.4
clerical, sales, technician	6	9.2	17	13.8
administration	13	20.0	15	12.2
teacher, nurse, social worker	11	16.9	26	21.1
lawyer, physician, professor	7	10.8	12	9.8
retired/disability	3	4.6	10	8.1

themselves attending a first session of psychotherapy. The hypothetical situation was described as a person seeking therapy because s/he was unhappy and experiencing relationshipdifficulties with a partner who wanted them to move in together. The person was afraid of her/his parents' reaction to them living together in a one-bedroom apartment. Six different therapy vignettes were constructed because of the six combinations of two independent variables, the therapist's sex (male, female) and the therapist's expressed attitudes towards coming-out to one's parents (positive, neutral, negative). See Appendix B for a brief description of the construction of the vignette and results of the pilot testing, Appendix C for the questionnaire employed in the pilot test and Appendix D for the therapy vignette.

Therapy Rating Form (TRF). The Therapy Rating Form (TRF), adapted for the current study and located in Appendix D, consists of the Counseling Concerns Scale (CCS), (McDermott et al., 1989), Counselor Rating Form (CRF), (Barak & LaCrosse, 1975), and some questions designed for the current study. The CCS is a list of 14 concerns that people commonly discuss with a therapist. Participants were asked to indicate on a 5-point Likert-type scale their comfort level (1 = very uncomfortable; 5 = very comfortable) in discussing each item with the hypothetical therapist in the hypothetical therapy situation. Items were selected by McDermott et al. (1989) to represent issues commonly brought to a university counselling centre. Items were rationally divided into two domains, central or peripheral to a person's sexual identity. Construct validity was demonstrated by the results from a Varimax factor analysis which confirmed the two-factor structure of the questionnaire with the exception of one item (#7, stressful issues at school or work overload). The items comprising the central to sexuality domain are #2, 3, 6, 8, 10, 11, 12, 13, 14 whereas the items comprising the peripheral domain are #1, 4, 5, 7 and 9.

The Counselor Rating Form (CRF) consists of 36 items, 12 each for the measurement

of counsellor attractiveness, counsellor expertness and counsellor trustworthiness. Each item is a rating on a 7-point, Likert-type bipolar scale. The CRF has been shown to have acceptable reliability and validity which suggests that it has reasonable clinical and research utility (Barak & LaCrosse, 1975; LaCrosse, 1980; LaCrosse & Barak, 1976). The CRF subscales of attractiveness, expertness and trustworthiness have been reported to have Spearman-Brown reliability coefficients of .85, .87 and .91, respectively. The CRF has been utilized in a variety of research which investigates the therapist-client relationship, including gay/lesbian research by Atkinson, Brady and Casas (1981) and Moran (1992).

In order to measure attitudinal similarity, the participants were asked to rate their agreement with the therapist's expressed attitude towards coming-out on a 7-point, Likert-type scale (1 = strongly disagree; 7 = strongly agree). As experimental manipulation checks, the participants were asked to speculate on the hypothetical therapist's sexual orientation. Participants were asked to rate their confidence in assuming that the therapist is gay, lesbian or bisexual on a 7-point, Likert-type scale (1 = not confident at all; 7 = very confident), and heterosexual on a similar rating scale. The last two ratings on the TRF asked the participants to rate how realistic the vignette was on a 7-point, Likert-type scale (1 = very unrealistic; 7 = very realistic) and how relevant it is to their personal lives (1 = irrelevant; 7 = relevant). Finally, the last portion of the TRF asked the participants to provide open-ended comments about what things a therapist might say that they would consider to be progay or antigay. They were instructed to use their personal therapy experience and/or knowledge of other people's experience.

Participant Questionnaire (PQ). The purpose of the PQ was to obtain various demographic data such as gender, age, education, occupation, income, ethnic/cultural background, sexual orientation and relationship status. See Appendix E for the PQ.

Participants were asked to indicate how which groups of people (friends, parents, siblings, coworkers, etc.) were aware of their sexual orientation, and to estimate the percentage of people who knew of their sexual orientation. These items were conceptualized as a behavioural measure of the participants' comfort with their sexuality. McDermott et al. (1989) found this to be statistically correlated with "internalized homophobia" as typically measured by the Index of Homophobia by Hudson and Ricketts (1980).

The PQ also requested information from participants who had received therapy such as the number of sessions attended, type of therapy and the therapists' credentials. Participants were also asked to rate their satisfaction with their therapy experience on a 7-point, Likert-type scale (1 = very dissatisfied; 7 = very satisfied), and to indicate if they have ever worked with a lesbian, gay or bisexual therapist. Finally, participants were asked to indicate their preference for a therapist's sexual orientation should they chose to go for therapy in the future (lesbian, gay male, bisexual male or female, heterosexual male or female, no gender and/or sexual orientation preference). The participants were also encouraged to describe their preferences and concerns in choosing therapist in their own words.

Procedure

As stated before, the participants were recruited from a number of different organizations including campus groups, social clubs, performance groups and church organizations. Mailing addresses and telephone numbers of various groups and organizations were selected from various reference guides for lesbians, gays and bisexuals in southern Ontario and metropolitan Detroit. A letter describing the study and my need for cooperation was sent to a representative of each group and telephone contact was made within two weeks. See Appendix F for the letter of introduction. The group/organization representative was

asked to represent me at their next meeting to discuss my request for their participation.

If possible, I asked the group's permission to attend a meeting in order to distribute questionnaire packages to interested participants. For the group meetings that I was able to attend, the group representative usually announced my presence. I briefly described the purposes of the study (to investigate the experiences of lesbians, gay men and bisexuals in different kinds of counselling situations), the contents of the questionnaire package and then asked for any questions. Details as to what I would do to ensure confidentiality and anonymity were also described. The questionnaire packages, which consisted of a cover letter (see Appendix G), consent form (see Appendix H), TRF, PQ, debriefing statement (see Appendix I) and a postage-paid return envelope, were distributed to interested participants as they left the meeting. The group representative was asked to thank the group members and remind them to complete the questionnaires at the next meeting. If it was impractical or unsuitable for me to attend a meeting in person, the representative was asked to coordinate the distribution of questionnaire packages. The representative was also asked to remind people at the next meeting to to take a few moments to complete and return the questionnaires if they had not already done so (telephone contact was typically made before this next meeting to remind the representative to make such an announcement).

Participants were also recruited by posting advertisements in gay-related community centres and newsletters which provided my work address and a toll-free telephone number. A brief description of the study and the details of what I did to ensure confidentiality and anonymity were provided if an interested participant contacted me by telephone. A questionnaire package was sent immediately and a reminder notice was sent within 14 days. Advertisements were also posted on 2 gay-related newsgroups on the Internet as well as an academic womens' issues discussion group. Interested participants replied by sending me a

notice via e-mail. I replied to these interested participants with a brief description of the study and details of what I would do to ensure confedentiality and anonymity. Interested participants sent me their postal addresses via e-mail if they found this agreeable. Questionnaire packages were mailed as soon as possible and reminder notices were sent via e-mail within 14 days.

CHAPTER III

RESULTS

The study had three components: (1) a survey which gathered information about various aspects of the participants as well as their experiences in therapy and preferences in choosing a therapist; (2) an experiment which measured the extent to which a therapist's gender and attitudinal similarity affected a participant's evaluations of a therapist and comfort in discussing personal issues; and (3) open-ended questions which asked participants for their preferences in picking a therapist and their thoughts about what progay or antigay statements a therapist might make.

Part I: Survey

Information was gathered on the participants' intimate relationships, comfort with their sexuality, therapy experiences and preferences in therapists from the Participant Questionnaire.

Relationship Status

Participants reported a diverse array of intimate relationships which are displayed in Table 3. Sixty-seven percent of the gay male participants reported that they were either dating different people on a regular basis, rarely dating, or not dating at all whereas only 24.6% of lesbian participants reported a similar situation. Eleven percent of the gay male participants reported that they were living with their partners in a committed, monogamous relationship whereas 52.3% of the lesbian participants were living with their partners. Results from non-parametric analyses suggested that these group differences in relationship status were significant, $\underline{X}^2$ (5, $\underline{N}$ = 188) = 46.99, $\underline{p}$ < .0000.

Table 3

Relationship Status

	Lesbians (N=65)		Gay Men (N=123)	
Relationship Type	#	%	#	%
Single, not/rarely dating	8	12.3	39	31.7
Single, regular dating	8	12.3	45	36.6
Dating 1 person (< 6 months)	7	10.8	14	11.4
Committed relationship (> 6 months)	6	9.2	11	8.9
Living with a partner	34	52.3	14	11.4
Living with partner and children	2	3.1	0	

Comfort with Sexuality

Participants' comfort with their sexuality was measured as well. One measure of comfort was the percentage of friends, family, colleagues and acquaintances who were aware of the participant's sexual orientation. This was phrased in the Participant Questionnaire as the percentage of people who the participants "knew well". Results from parametric statistical analyses did not suggest any group differences in comfort with sexuality. The participants reported, on average, that 75.6% of their friends, family, colleagues and acquaintances were aware of their sexual orientation (SD = 26.24). The reported percentages ranged from 0% to 100% with a negatively skewed distribution (Median = 85.0).

Comfort with sexuality was also measured by asking the participants to indicate which types of people were aware of their sexual orientation. Table 4 displays the number of participants who were "out" to various types of people. Results from non-parametric analyses, however, did not suggest any significant group differences.

Therapy Experience

A considerable amount of information regarding previous therapy experience was gathered in the survey. The majority of participants reported previous therapy experience. Overall, 92.3% of the lesbian participants and 74% of the gay male participants reported some form of therapy experience since adolescence. Results from non-parametric statistical analyses suggested that these groups differences in therapy experience were significant, X^2 (1, N = 188) = 9.03, $p < .005$. In other words, a relatively smaller proportion of male participants reported previous therapy experience compared to female participants. Overall, participants reported an average of three different therapy experiences. Results from parametric statistical analyses did not suggest any significant group differences in the

Table 4

Number of Participants who are "Out" to Various Types of People

	Lesbians (N=65)		Gay Men (N=123)	
Types of People	#	%	#	%
Parents	53	81.5	100	81.3
Siblings	52	80.0	91	74.0
Other Relations	30	46.2	61	49.6
Close Friends	61	93.8	118	95.9
Casual Friends	41	63.1	89	72.4
Neighbours	32	49.3	52	42.3
Coworkers/Classmates	48	73.8	91	74.0
Employers/Professors	42	64.6	82	66.7

number of therapy experiences.

Participants also provided information regarding the different types of therapists that they had worked with (see Table 5). The majority of lesbian and gay male participants reported that they had worked with "mainstream" or traditional therapists (clinical or counselling psychologists, social workers, psychiatrists). Since many participants reported multiple therapy experiences with different kinds of therapists, a two-way Chi-square analysis was not appropriate. Results from individual Chi-square analyses did not suggest any significant group differences in experiences with psychologists, psychiatrists, psychotherapists or pastoral counsellors.

Information was also gathered about the participants' experiences with different types of therapy (see Table 6). The majority of participants with therapy experience reported more cases of individual therapy compared to couple, family or group therapy. No significant differences in experiences with individual, group or peer-support therapy existed between the lesbian and gay male participants. The only significant group difference observed was with couple therapy, $\underline{X}^2$ (1, $\underline{N}$ = 150) = 4.46, $\underline{p} < .05$. Thirty-four percent of the lesbian participants with therapy experience reported couple therapy experience compared to only 19% of the gay male participants. Results from non-parametric analyses also suggested that gay male participants had significantly less experience with long-term therapy compared to lesbian participants, $\underline{X}^2$ (1, $\underline{N}$ = 152) = 4.06, $\underline{p} < .05$. No other significant group differences in therapy were suggested.

Information was also gathered about the participants' experiences with lesbian, gay or bisexual therapists (see Table 7). Results from non-parametric statistical analyses suggested that relatively more lesbian participants had worked with lesbian therapists than gay male participants, $\underline{X}^2$ (1, $\underline{N}$ = 148) = 17.38, $\underline{p} < .0001$. Relatively more gay male participants

Table 5

Number of Participants who have Worked with Different Types of Therapists

	Lesbians (N=60)		Gay Men (N=91)	
Therapist Type	#	%	#	%
Psychologist (Clinical or Counselling)	31	52.5	46	50.5
Social Worker	29	49.2	38	41.8
Psychiatrist	23	39.0	36	39.6
Pastoral Counsellor	8	13.6	8	8.8
Psychotherapist	13	22.0	13	14.3

Total percentages may exceed 100 because some participants have multiple therapy experiences

Table 6

Types of Therapy Experiences for Participants

	Lesbians (N=60)		Gay Men (N=91)	
Type of Therapy	#	%	#	%
Individual Therapy	54	91.5	86	92.5
Couple Therapy	20	33.9	17	18.7*
Family Therapy	7	11.9	11	12.1
Group Therapy	12	20.3	23	25.3
Peer-Support Group	19	32.2	32	35.2
Duration of Therapy				
Consultation[a]	7	12.5	10	11.8
Short-Term Therapy[b]	38	67.9	55	64.7
Long-Term Therapy[c]	40	71.4	49	57.6*
Inpatient Hospitalization	4	7.1	2	2.4

Total percentages may exceed 100 because some participants have multiple therapy experiences

a. consultation is 1 session

b. short-term therapy is less than 16 sessions

c. long-term therapy is more than 16 sessions

* $p < .05$

Table 7

Number of Participants who have Worked with a Lesbian, Gay or Bisexual Therapist

	Lesbians		Gay Men	
Therapist Type	#	%	#	%
Lesbian Therapist	24	40.7	10	11.2**
Gay Male Therapist	2	3.4	20	22.5*
Bisexual Female Therapist	1	1.7	0	
Therapist's Sexuality was Unknown	8	13.5	20	22.5
Heterosexual Therapist	24	40.7	41	43.8
Total	59	100.0	91	100.0

* $p < .005$ and ** $p < .0001$

had worked with gay male therapists compared to lesbian and bisexual female participants, X^2 (1, N = 148) = 10.21, $p < .005$. There were no other significant group differences.

Information about the participants' satisfaction with previous therapy was also gathered by asking participants to make ratings on 7-point Likert-type scales (1 = very dissatisfied to 7 = very satisfied). The participants' satisfaction ratings are displayed in Table 8. Results from independent t-tests did not suggest any significant group differences in the mean satisfaction ratings of heterosexual therapists or the mean satisfaction ratings of gay, lesbian or bisexual therapists. Interesting differences in the mean satisfaction ratings, however, were observed between participants who had worked with a lesbian, gay or bisexual therapist and participants who had only worked with a heterosexual therapist or a therapist of unknown sexual orientation. The mean satisfaction rating by lesbians who had only worked with a heterosexual therapist or a therapist of unknown sexual orientation was significantly lower than the mean satisfaction rating by lesbians who had worked with a lesbian, gay or bisexual therapist, t (57) = -2.53, $p < .05$. Similar differences in the mean satisfaction ratings by gay male participants were non-significant.

Preferences in Therapists

Information was also gathered on the participants' preferences in choosing a therapist. Participants were asked to indicate how much a therapist's gender and sexual orientation mattered to them on 7-point Likert-type scales (1 = not at all, 7 = very much). The mean preference rating was 4.51 (SD = 1.87). No significant group differences were found in the mean preference ratings for the therapist's sexual orientation. Therefore, a therapist's sexual orientation was no more important for lesbian participants than gay male participants. However, significant group differences in the mean preference ratings for the therapist's

Table 8

Participants' Satisfaction with Therapy

	Lesbians (N=60)	Gay Men (N=91)
Therapist Sexual Orientation		
Heterosexual or Unknown	4.97(2.12)$_a$	4.81(1.96)
Lesbian/Gay/Bisexual	6.06(0.87)$_a$	5.38(1.85)
Therapy Duration		
Consultation	2.20(2.68)	2.58(2.37)
Short-Term Therapy	3.57(2.00)	3.73(1.97)
Long-Term Therapy	5.44(1.48)	4.98(1.74)

Higher scores indicate greater satisfaction (1=very dissatisfied, 7=very satisfied); Means with the same subscripts are significantly different at $p < .05$ by the Tukey honestly significant difference comparison

gender were suggested, $t(185) = -4.17$, $p < .0001$. The mean preference rating by lesbian participants was 5.49 compared to 4.18 by gay male participants ($SD = 2.11$ and 1.89, respectively).

Significant differences were also observed within each participant group in their preference ratings for a therapist's gender and sexual orientation. Gay male participants indicated that a therapist's sexual orientation ($M = 4.54$, $SD = 1.98$) was more important than a therapist's gender ($M = 4.18$, $SD = 2.11$), $t(121) = 2.02$, $p < .05$. Conversely, a therapist's gender was more important than sexual orientation for lesbians. The mean preference rating for a therapist's gender by lesbian participants was 5.49 compared to 4.60 for a therapist's sexual orientation, ($SD = 1.89$ and 1.59, respectively), $t(64) = -3.21$, $p < .005$.

Participants were also asked to indicate which gender and/or sexual orientation of a therapist they would prefer to work with. Table 9 displays the types of therapists indicated by participants. In general, participants chose to work with a therapist who had the same gender and sexual orientation. That is, relatively more lesbian participants indicated a preference for a lesbian therapist than gay male participants, X^2 (1, $N = 149$) = 83.21, $p < .0000$. Relatively more gay male participants indicated a preference for a gay male therapist than lesbian participants, X^2 (1, 148) = 63.50, $p < .0000$.

Part II: Experiment

The purpose of the experiment was to assess the extent to which a therapist's gender and attitudinal similarity affects a lesbian, gay male or bisexual person's therapy experience. The experiment had a completely randomized, 2 (therapist gender) X 3 (expressed attitude), factorial design. In the hypothetical therapy vignettes, the therapist was either male or female

Table 9

Participants' Preferences for a Therapist's Sexual Orientation

	Lesbians		Gay Men	
Therapist Type	#	%	#	%
Lesbian	51	78.5	8	6.5*
Gay Male	0		68	55.3*
Lesbian or Gay Male	1	1.5	4	3.3
Bisexual Female	1	1.5	3	2.4
Bisexual Male	0		3	2.4
Gay or Bisexual Male	0		2	1.6
Lesbian or Heterosexual Female	3	4.6	0	
Heterosexual Female	3	4.6	9	7.3
Heterosexual Male	4	6.2	1	0.8
Female Only (no sexuality preference)	0		0	
Male Only (no sexuality preference)	0		3	2.4
No Gender or Sexuality Preference	2	3.1	22	17.9
Total	65	100.0	123	100.0

* $p < .0000$

and the expressed attitudes toward coming-out that were either positive, neutral or negative. Three of the five dependent measures were the participants' evaluations of the hypothetical therapist's attractiveness, expertness and trustworthiness as measured by the Counselor Rating Form (Barak & LaCrosse, 1975). The two remaining dependent measures were the participants' ratings of comfort in discussing issues central and peripheral to their sexuality as measured by the Counseling Concerns Scale (McDermott, Tyndall & Lichtenberg, 1989).

The relationships between the independent variables and the five dependent variables were investigated by employing five standard multiple regression analyses using SSPS^{X}. The five dependent measures were the scores from the CRF and CCS whereas the independent variables in each multiple regression model were the two background characteristics (comfort with sexuality and previous therapy experience), agreement with the therapist, the two manipulated variables (therapist gender and expressed attitudes towards coming-out) and the interaction between the two variables. For the lesbian participants, previous therapy experience was not included in the analyses as an independent variable as there were not enough participants without previous therapy experience for this to be a useful predictor in the multiple regression analyses. Since five multiple regression models were testedindependently, Bonferroni adjustments to the F values were made in order to correct for family-wise Type I error. The data from the lesbian and gay male participants were analyzed separately in order to respect the inherent differences between these groups of people. Separate analyses of the data were also warranted because of the significant differences in recruitment strategies between the participant groups.

Evaluations of the Therapy Vignette

The participants made a number of judgements of the therapy vignette regarding its

realism and relevance to the participants' personal lives. Results from an analysis of variance suggested that the therapist's expressed attitudes toward coming-out (positive, neutral or negative) as well as the gender of the therapist and participant did not influence the participants' ratings of realism. The mean realism rating was 4.82 (SD = 1.84). Results from another analysis of variance suggested that the participants' ratings of personal relevance were not influenced by the participants' gender nor the therapist's expressed attitudes (positive, neutral or negative). The mean relevance rating was 4.39 (SD = 1.84).

The participants were also asked to indicate how confident they were in speculating on the hypothetical therapist's sexual orientation. Results from an analysis of variance suggested that the participants' confidence ratings in assuming that the hypothetical therapist was heterosexual were significantly influenced by the attitude condition (positive, neutral or negative), $F(2, 188) = 39.90$, MSE = 2.69, $p < .0001$. The mean confidence ratings in assuming that the therapist was heterosexual are displayed in Table 10. Post-hoc comparisons utilizing Tukey's honestly significant difference suggested that participants were more confident in assuming that the therapist was heterosexual when s/he expressed negative attitudes toward coming-out whereas participants were less confident when the therapist made neutral or positive comments. Results from an analysis of variance suggested that the participants' confidence in assuming that the therapist was lesbian, gay or bisexual were influenced by the attitude condition but not the therapist's or participants' gender, $F(2, 188) = 12.70$, MSE = 1.90, $p < .0001$. The mean confidence ratings in assuming that the therapist was lesbian, gay or bisexual are also displayed in Table 10. Post-hoc comparisons utilizing Tukey's honestly significant difference suggested that the participants were more confident in assuming that the therapist was lesbian, gay or bisexual when the therapist expressed positive attitudes toward coming-out whereas they were less confident when the

Table 10

Participants' Confidence Ratings in Assuming the Therapist's Sexual Orientation

	Therapist's Sexual Orientation	
Attitude Condition	Heterosexual M(SD)	Lesbian, Gay or Bisexual M(SD)
Positive	3.71(1.66)	3.11(1.59)*
Neutral	4.66(1.78)	2.32(1.43)**
Negative	5.78(1.50)	1.62(1.10)**

Mean ratings range from 1 (not confident at all) to 7 (very confident); * $p < .05$ and ** $p < .0001$

therapist made neutral or negative comments.

Results also suggested that participants were more willing to assume that the therapist was heterosexual, regardless of what the hypothetical therapist said about coming-out. For example, participants were more willing to speculate that the therapist was heterosexual than lesbian, gay or bisexual when the therapist made positive comments on coming-out, t (67) = 2.13, $p < .05$, respectively. It appears that the participants needed more information on the therapist in order to speculate that the therapist was lesbian, gay or bisexual.

Evaluations of the Therapist

Gay Male Participants. The results of the regressions for the gay male participants' evaluations of the therapist are displayed in Table 11 (see Appendix J for the correlations between the variables for each regression model). Only agreement with the therapist's expressed attitudes towards coming-out contributed significantly to the prediction of the gay males' evaluations of the therapist's attractiveness and trustworthiness (sr^2 = .05 and .04, respectively).

Altogether, 31% (28% adjusted) of the variability in the gay male participants' ratings of the therapist's attractiveness was predicted by knowing the scores on all six independent variables whereas 36% (33% adjusted) of the variance in the ratings of the therapist's trustworthiness was predicted. The therapist's expressed attitudes toward coming-out did not make a significant contribution to the prediction of the gay males' ratings of the therapist's attractiveness or trustworthiness in the original regression models. However, post-hoc evaluations revealed that the attitude condition (positive, neutral or negative) could predict the gay males' ratings of the therapist's attractiveness and trustworthiness by itself, $F(6, 108)$ = 5.22, $p < .0001$ and $F(6, 107) = 3.67$, $p < .005$, respectively. Therefore, it is reasonable

Table 11

Summary of Standard Regression Analysis for Variables Predicting Gay Male Participants' Evaluations of the Therapist

Variable	B	SE B	beta
ATTRACTIVENESS			
Agreement with Attitude	0.128	0.05	.31**
Comfort with Sexuality	0.002	0.00	.07
Therapy Experience	-0.364	0.19	-.16
Attitude	0.168	0.31	.14
Therapist Sex	-0.615	0.43	-.31
Attitude x Therapist Sex	-0.346	0.19	-.58
R^2 = .31, Adjusted R^2 = .28, R = .56, $F(6, 108)$ = 8.21, p < .0000			
EXPERTNESS			
Agreement with Attitude	0.280	0.05	.54***
Comfort with Sexuality	0.001	0.00	.03
Therapy Experience	-0.210	0.21	-.08
Attitude	0.587	0.35	.40
Therapist Sex	-1.112	0.49	-.47*
Attitude x Therapist Sex	-0.470	0.22	-.66*
R^2 = .38, Adjusted R^2 = .36, R = .62, $F(6, 110)$ = 11.20, p < .0000			
TRUSTWORTHINESS			
Agreement with Attitude	0.244	0.05	.54***
Comfort with Sexuality	0.001	0.00	.04
Therapy Experience	-0.196	0.20	-.08
Attitude	0.362	0.32	.28
Therapist Sex	-0.817	0.45	-.39
Attitude x Therapist Sex	-0.305	0.20	-.48
R^2 = .36, Adjusted R^2 = .33, R = .60, $F(6, 107)$ = 10.24, p < .0000			

* p < .05, ** p < .01, *** p < .0000

to assume that the correlation between the attitude condition and the ratings of the therapist'sattractiveness as well as the attitude condition and the ratings of the therapist's trustworthiness in the original regression models may have been mediated by other independent variables, namely the participants' ratings of agreement with the therapist. The correlation between the attitude condition and the participants' ratings of agreement with the therapist in both regression models was -.67 which suggests that gay male participants agreed with the therapist in the positive attitude condition and disagreed in the negative attitude condition. These results provide support for the hypothesis that the evaluations of a therapist would be more positive if participants agreed with the hypothetical therapist's comments on coming-out.

The gay males' ratings of the therapist's expertness were predicted by their agreement with the therapist's expressed attitudes as well as the therapist's gender and an interaction between the therapist's gender and the therapist's expressed attitude ($\underline{sr}^2$ = .04, .02 and .03, respectively). Altogether, 38% (36% adjusted) of the variability in the gay males' ratings of the therapist's expertness was predicted by knowing the scores on all six independent variables. The significant interaction between the two independent factors (the therapist's expressed attitude and therapist gender) suggests that the effects of the therapist's expressed attitude towards coming-out on the gay males' evaluations of the therapist's expertness were mediated to some extent by the therapist's gender. Table 12 displays the mean expertness ratings by the gay male participants across all six conditions and Figure 1 is a graphical representation. The highest mean expertness rating was for a female therapist who expressed positive attitudes towards coming-out whereas the lowest rating was for the female therapist who expressed negative attitudes. Post hoc comparisons utilizing Tukey's honestly significant difference test suggested that the mean expertness rating for the a female therapist who

Table 12

Mean Expertness Ratings Across All Six Conditions by Gay Male Participants

	Therapist Sex	
Expressed Attitude	Male	Female
Positive	4.52(1.12)	$5.38(1.09)_{a,b}$
Neutral	$4.65(0.89)_{c}$	$4.70(0.80)_{d}$
Negative	$3.77(1.29)_{a}$	$3.62(1.08)_{b,c,d}$

higher scores reflect higher evaluations of therapist expertness; scores with the same subscripts are significantly different from each at $p < .05$ in the Tukey's honestly significant difference comparison

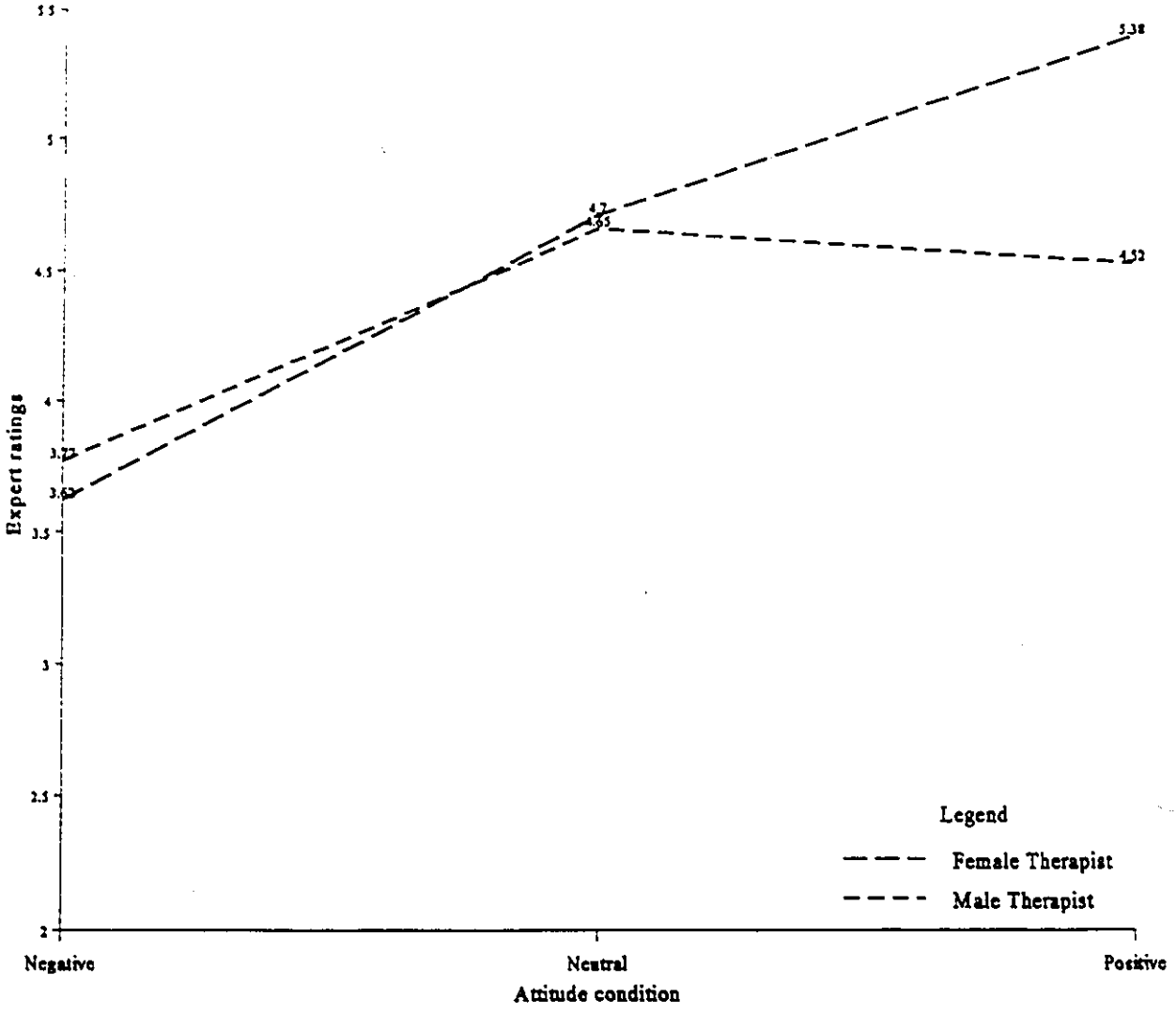

Figure 1. Expertness Ratings by Gay Male Participants Across All Six Conditions

expressed positive attitudes was significantly higher than the ratings of therapists who expressed negative attitudes, regardless of sex. However, the mean expertness rating of a female therapist in the positive attitude condition was not significantly different from that of a male therapist who made the same comments. The female therapist who expressed negative attitudes towards coming-out also received significantly lower expertness ratings compared to a therapist who made neutral comments, regardless of sex. Again, the mean expertness rating of a female therapist in the negative attitude condition was not significantly different than the mean expertness rating of a male therapist who made the same comments. In summary, results from post-hoc comparisons suggested that gay male participants' evaluations of a male therapist's expertness were not influenced significantly by his comments on coming-out. However, a female therapist who made negative comments was perceived to be less expert than a female therapist who made positive or neutral comments on coming-out.

Lesbian Participants. The results from the regressions of the lesbian participants' evaluations of the therapist are displayed in Table 13. Similar results to those found for gay men were observed for the lesbian participants' evaluations of the therapist. Only the participants' agreement with the therapist's attitudes toward coming-out contributed significantly to the prediction of the the participants' ratings of the therapist's expertness and trustworthiness (sr^2 = .03 and .04, respectively). Altogether, 33% (27% adjusted) of the variability in the lesbians' ratings of the therapist's expertness and 36% (30% adjusted) of the variability in the ratings of the therapist's trustworthiness were predicted by knowing the scores on all five independent variables.

Similar to the results from the gay male participants, the therapist's expressed attitudes did not contribute significantly to the prediction of the lesbians' evaluations of the therapist. However, post-hoc evaluations revealed that the therapist's attitudes could predict

Table 13

Summary of Standard Regression Analyses for Variables Predicting Lesbian Participants' Evaluations of the Therapist

Variable	B	SE B	beta
ATTRACTIVENESS			
Agreement with Attitude	0.063	0.06	.19
Comfort with Sexuality	0.003	0.00	.12
Attitude	-0.182	0.34	-.21
Therapist Sex	-0.341	0.45	-.24
Attitude x Therapist Sex	-0.142	0.21	-.31
R^2 = .31, Adjusted R^2 = .25, R = .56, $F(5, 56) = 5.05$, $p < .001$			
EXPERTNESS			
Agreement with Attitude	0.241	0.08	.53*
Comfort with Sexuality	0.005	0.00	.13
Attitude	0.014	0.46	.01
Therapist Sex	-0.111	0.60	-.06
Attitude x Therapist Sex	-0.100	0.27	-.16
R^2 = .33, Adjusted R^2 = .27, R = .57, $F(5, 56) = 5.45$, $p < .0005$			
TRUSTWORTHINESS			
Agreement with Attitude	0.187	0.07	.44**
Comfort with Sexuality	0.002	0.00	.02
Attitude	-0.295	0.40	-.27
Therapist Sex	0.080	0.53	.04
Attitude x Therapist Sex	0.049	0.24	.08
R^2 = .36, Adjusted R^2 = .30, R = .60, $F(5, 63) = 5.63$, $p < .0001$			

* $p < .01$, ** $p < .005$

lesbian participants' ratings of expertness and trustworthiness by itself, F (5, 56) = 2.78, $p <$ .025 and F (5, 57) = 4.23, $p < .0005$. Again, the relationship between the therapist's attitudes and the ratings of the therapist's trustworthiness may have been mediated by its correlations with other independent variables, namely the participants' ratings of agreement with the therapist. The correlation between the therapist's expressed attitudes and the participant's ratings of agreement with the therapist's expressed attitudes in each regression model was -.74 which suggests that lesbian participants agreed with the therapist in the positive attitude condition and disagreed in the negative attitude condition. In summary, these results support the hypothesis that participants would evaluate a therapist more favourably if they agreed with a therapist's comments on coming-out.

In terms of predicting lesbian participants' evaluations of the therapist's attractiveness, R for regression was significant but none of the independent variables made a unique significant contribution to the regression. Altogether, 31% (25% adjusted) of the variability in in the participants' ratings of the therapist's attractiveness was predicted by knowing scores on all five independent variables.

Comfort Ratings

Gay Male Participants. The results of the regression predicting gay male participants' ratings of comfort in discussing issues central and peripheral to their sexuality are displayed in Table 14. Only the participants' ratings of agreement with the therapist's expressed attitudes toward coming-out contributed significantly to the prediction of of the gay male participants' ratings of comfort in discussing issues central to their sexuality ($sr^2 = .04$). Altogether, 19% (15% adjusted) of the variability in the comfort ratings of discussing issues central to their

Table 14

Summary of Standard Regression Analysis for Variables Predicting Gay Male Participants' Comfort Ratings of Discussing Personal Issues

Variable	B	SE B	beta
CENTRAL ISSUES			
Agreement with Attitude	0.178	0.06	.35*
Comfort with Sexuality	0.001	0.00	.02
Therapy Experience	-0.107	0.24	-.04
Attitude	-0.024	0.40	-.02
Therapist Sex	-0.401	0.56	-.17
Attitude x Therapist Sex	-0.078	0.25	-.11
R^2 = .19, Adjusted R^2 = .15, R = .44, $F(6, 114) = 4.50$, $p < .0005$			
PERIPHERAL ISSUES			
Agreement with Attitude	0.096	0.06	.20
Comfort with Sexuality	-0.004	0.00	-.09
Therapy Experience	0.010	0.24	.00
Attitude	-0.020	0.40	-.01
Therapist Sex	-0.478	0.56	-.21
Attitude x Therapist Sex	-0.129	0.25	-.18
R^2 = .12, Adjusted R^2 = .07, R = .34, $F(6, 112) = 2.50$, $p < .05$			

* $p < .005$

sexuality was predicted by knowing the scores on all six independent variables. Even though the therapist's expressed attitude toward coming-out did not make a significant contribution to the prediction of participants' comfort ratings in discussing issues central to their sexuality in the original regression model, post-hoc evaluations indicated that the therapist's expressed attitudes could predict the comfort ratings by itself, F (6, 114) = 2.23, $p < .05$. Again, the correlation between the therapist's expressed attitudes and the participants' ratings of agreement with the therapist ($r = -.66$) suggests that the gay male participants tended to agree with the therapist's positive comments on coming-out and disagree with the negative comments. Therefore, there was support for the hypothesis that participants would feel more comfortable in discussing issues central to their sexuality if a they agreed with their therapist's expressed attitudes toward on coming-out.

In terms of predicting the gay male participants' comfort in discussing issues peripheral to their sexuality, R for regression was significant but none of the independent variables made a significant unique contribution to regression. Only 12% (7% adjusted) of the variability in the gay male participants' ratings of comfort in discussing issues peripheral to their sexuality was predicted by knowing the scores on all six independent variables. Therefore, the results support the hypothesis that participants' comfort in discussing issues peripheral to their sexuality would not be influenced by a therapist's comments.

Lesbian Participants. The results of the regressions predicting lesbian participants' comfort ratings in discussing issues central and peripheral to their sexuality are displayed in Table 15. Only the therapist's expressed attitudes made a significant contribution to the prediction of the lesbian participants' ratings of comfort in discussing issues central to their sexuality ($sr^2 = .04$). Altogether, 50% (45% adjusted) of the variability in the lesbian participants' ratings of comfort in discussing something central to their sexuality was predicted

Table 15

Summary of Standard Regression Analysis for Variables Predicting Lesbian Participants' Ratings of Discussing Personal Issues

Variable	B	SE B	beta
CENTRAL ISSUES			
Agreement with Attitude	0.141	0.08	.26
Comfort with Sexuality	-0.002	0.00	-.05
Attitude	-0.997	0.47	-.72*
Therapist Sex	0.229	0.61	.10
Attitude x Therapist Sex	0.275	0.28	.38
R^2 = .50, Adjusted R^2 = .45, R = .71, $F(5, 56) = 11.18$, $p < .0000$			
PERIPHERAL ISSUES			
Agreement with Attitude	0.121	0.09	.23
Comfort with Sexuality	-0.009	0.01	-.19
Attitude	-1.239	0.54	-.91*
Therapist Sex	1.501	0.72	.67*
Attitude x Therapist Sex	0.742	0.33	1.05*
R^2 = .26, Adjusted R^2 = .20, R = .51, $F(5, 57) = 4.08$, $p < .005$			

* $p < .05$

by knowing scores on all five independent variables. Therefore, the results supported the hypothesis that participants would feel more comfortable in discussing issues central to their sexuality with a therapist who made positive comments on coming-out.

In terms of predicting the lesbian participants' ratings of comfort in discussing issues peripheral to their sexuality, the therapist's expressed attitude and gender as well as the interaction between these two independent variables made significant contributions ($\underline{sr}^2$ = .07, .06 and .07, respectively). Altogether, 26% (20% adjusted) of the variability in the lesbian participants' comfort in discussing issues peripheral to their sexuality was predicted in this regression model. The significant interaction between the two independent factors suggested that the effects of the therapist's expressed attitude on the participants' comfort in discussing issues peripheral to their sexuality was mediated to some extent by the therapist's gender. Table 16 displays the lesbian participants' ratings of comfort in discussing issues peripheral to their sexuality across all six conditions whereas Figure 2 is a graphical representation. Post-hoc comparisons utilizing Tukey's honestly significant difference method suggested that the mean comfort rating for a male therapist who made positive comments on coming-out was significantly higher than the mean comfort rating for a male therapist who made negative comments. In summary, results suggested the lesbian participants' ratings of comfort in discussing issues peripheral to their sexuality with a female therapist were not significantly influenced by her comments on coming-out. However, lesbian participants would feel relatively less comfortable in discussing issues that were not central to their sexuality with a male therapist who made negative comments on coming-out compared to a male therapist who made positive comments.

Table 16

Mean Ratings of Comfort in Discussing Issues Peripheral to Sexuality Across All Six Conditions by Lesbian Participants

	Therapist Sex	
Expressed Attitude	Male	Female
Positive	$4.16(0.85)_a$	3.47(1.14)
Neutral	3.61(0.79)	3.78(1.28)
Negative	$2.62(1.14)_a$	3.27(1.00)

ratings with the same subscripts are significantly different at $p < .05$ in the Tukey's honestly significant difference comparison

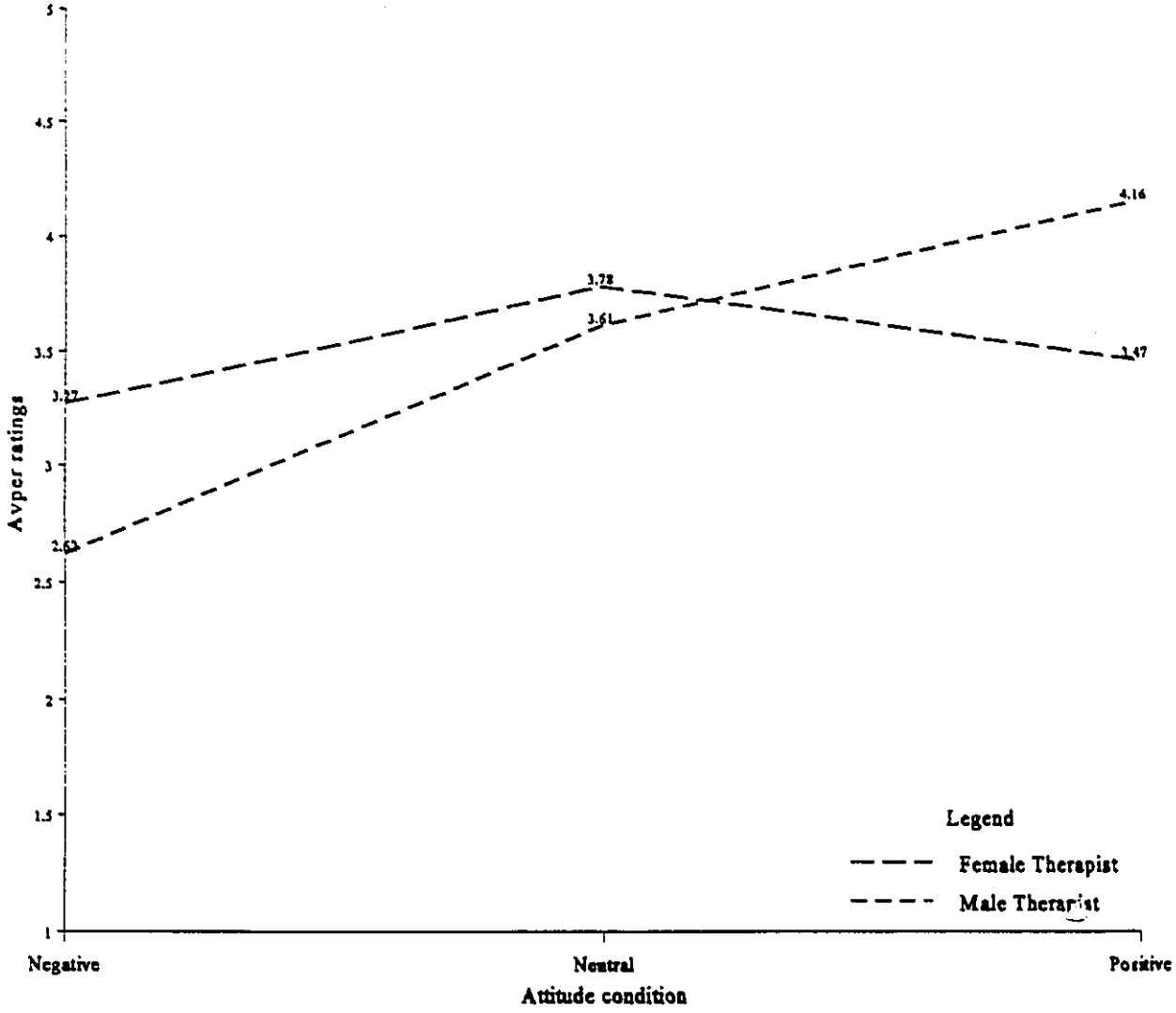

Figure 2. Mean Comfort Ratings in Discussing Peripheral Issues by Lesbian Participants Across All Six Conditions

Part III: Open-Ended Comments

Participants provided their personal comments regarding two issues: (1) their concerns and preferences in choosing a therapist as asked in the Participant Questionnaire; and (2) their ideas as to what types of "antigay" and "progay" things a therapist might say as asked in the Therapy Rating Form. Many participants also provided their personal therapy experiences which ranged from positive to negative. See Appendix K for all of the personal therapy experiences reported by the participants. Ninety percent of the participants provided some form of open-ended comments which ranged from a few point-form words to two pages of text. These open-ended comments were analysed in a manner which resembled a grounded-theory analysis (Strauss & Cobrin, 1990). For each question, the participants' written comments were separated into individual meaning units which were then grouped together according to a thematic connection. These inductively derived themes were intended to organize the participants' responses so they could be interpreted usefully. However, it was not intended for these themes to compromise the diversity of the participants' responses nor were they intended to be mutually exclusive. For each question, the themes were arranged in a hierarchial order, with the most prevalent theme listed first.

Preferences in Choosing a Therapist.

Table 17 summarizes the themes of the participants' comments regarding their preferences and concerns in choosing a therapist. The themes are presented in rank-order of prevalence in which Theme I was most predominant and subsequent themes were less common.

Theme I: Therapist's Sexual Orientation and/or Gender. The participants expressed numerous preferences for different kinds of therapists for diverse reasons. The most common

Table 17

Participants' Preferences in Choosing a Therapist

		Frequency
I.	Therapist's sexual orientation and/or gender	65
II.	Therapist's competence and/or experience in therapy	42
III.	Therapist's experience and/or comfort with lesbians, gay men and bisexuals	22
IV.	Particular therapeutic styles/approaches	
	A. Emotion-focused and/or non-directive	12
	B. Problem-focused and/or directive	5
V.	Other therapist-client similarities	
	A. Sociopolitical views	5
	B. Cultural Background	4
VI.	Practical Considerations	2

preference was for a therapist of a particular sexual orientation and/or gender. Many of the gay male participants expressed a preference for a gay male therapist because his similar life experiences were of prime importance. "He must know from personal experiences, not from reading about them" (Dan, GM)[1]. "I am pretty deeply steeped in the gay life. I want someone I can talk to without translating for him" (John, GM). "I suppose I would prefer a gay male because I'm very linked to my sexuality and would need someone who didn't have to attempt to imagine my struggles...someone who had experienced it first hand would understand it better" (Joe, GM). Some gay male participants simply believed that similarities in gender and sexual orientation would guarantee better services. "I know that the therapist's word would be more sincere and believable if I know that he was gay. He would understand my feelings better than a heterosexual" (Salim, GM). "A gay male therapist would have a more realistic outlook" (Gerry, GM).

To a lesser extent, some gay male participants expressed a preference for a therapist who was gay, lesbian or bisexual. In other words, the therapist's sexuality was important but not his/her gender. "I believe a person with a gay or lesbian orientation will have had far more experience and will be able to sympathize and relate to my situation" (Scott, GM). "A gay, lesbian, or bisexual therapist would be on the same 'wavelength' when I talk about relationships" (Doug, GM). One gay male participant acknowledged that a heterosexual therapist could probably learn about gay/lesbian issues but "most straight therapists have not been adequately trained to deal with lgb [lesbian/gay/bisexual] clients nor do they share the history required for adequate empathy" (Paul, GM). Finally, a few gay male participants expressed a preference for female therapists of any sexual orientation. "I feel accepted by females. They are better listeners" (Mike, GM). "I find I can communicate better with women

[1] All names have been changed to ensure anonymity; GM refers to gay male whereas L refers to lesbian.

(hetero or not)" (Phil, GM). A few participants preferred to work with a female therapist because they feared sexual advances from a gay male therapist. "I would want a heterosexual female therapist...a gay male therapist might make a pass at me" (Rex, GM). "I feel a lesbian would be the best choice as no sexual issues would interfere with my therapy" (Brian, GM).

Many of the lesbians participants stated that they could only work with a lesbian therapist. "I would feel more comfortable talking to a lesbian...I just think that she would be more aware and in touch with my feelings because she had been there too" (Sandra, L). "In a lot of ways, I see a therapist as a kind of role model...a therapist like me would be most understanding and preferable" (Joanne, L). "...I can talk more openly [with a lesbian therapist] because I am automatically more comfortable with her" (Amber, L). Even if a lesbian therapist was preferred, there were reservations cited by some participants, "...however, due to the size of our community, I would really have to trust her...it can be awkward to run into your therapist in social settings" (Donna, L). There were also many lesbian participants who reported that they preferred a female therapist yet her sexual orientation was not as important. "It must be a woman, I am more relaxed, trusting and open...it would depend more on the person than the sexual orientation" (Dorothy, L). "...I find them [females] more receptive. There [sic] sexual orientation is not a priority. I only care that she can respect and accept my sexual orientation" (Angie, L). "A counselor must be female...I find it difficult, almost laughable to believe that a male counselor could really grasp and/or identify where I was coming from...the sexual orientation is not so important" (Beth, L).

To a lesser extent, some lesbian participants reported that the therapist's gender did not really matter whereas the sexual orientation did. "I would want a lgb...that would eliminate a whole bunch of explaining before we could get to the heart of the matter" (Lori, L). "I would want a lesbian or gay therapist...they are better qualified to deal with the issues due to their

personal knowledge or experience" (Rachel, L). "I would look for a homosexual or bisexual counselor who was fairly young. I feel that these two factors are necessary for this counselor to truly understand what I am going through" (Ava, L). Finally, a few lesbian participants expressed a desire to work only with heterosexual and/or male therapists. "I prefer male therapists. I find talking with women too revealing and I do not trust them as much as I trust a man in a counseling environment" (Nicole, L). One lesbian participant reported:

> I prefer men as therapists. I don't have to be concerned about developing a "crush" which seems to have happened more than once when I've had women therapists...I think that I would prefer a straight man...they would bring a balanced perspective. Sometimes I don't understand hetero [sic] thinking and they can balance that for me. Because the gay community is so small and incestuous, I might know a gay therapist and his friends. I prefer the anonymity of a het [sic] (Lucinda, L).

Another lesbian participant wrote:

> I think that it would be nice to see a middle-aged feminist straight woman. Sometimes I feel that lesbians over-identify with the problems and issues and think everything is political oppression. A straight woman with political sensibilities would bring a new and interesting perspective in my counseling and perhaps I could teach her something too! (Teresa, L).

Theme II: A Competent and/or Experienced Therapist. The second most predominant theme in the participants' comments regarding their preferences in choosing a therapist was a concern for an experienced and competent therapist. "My concern for a therapist would be that the individual be qualified...he or she has to be able to communicate effectively and affectively" (George, GM). "I really don't have a strong preference as to the gender or sexual orientation of a counselor...my main concern would be their professionalism and ability to help resolve my issues" (Chris, GM). One lesbian participant was not sure about an "absolute relationship between a therapist's sexual orientation and his or her ability to understand and facilitate my growth. There are plenty of dogmatic and controlling people in our community" (Carol, L). "It is most important that the person is a good therapist, not necessarily a lesbian

therapist...it is important for me to search for a therapist who I feel is most informed in the areas in which I am seeking support" (Romina, L).

Of course, there was a variety of criteria for evaluating competence and experience. "I would just like them to be intelligent, skilled, open and non-judgmental on any personal, ethical or moral standpoint" (Warren, GM). "I'm looking for a mature, responsible, respectful, professional, unbiased individual who has the resources and ability to assist me through any difficult time" (Charles, GM). "I would require a therapist to have specialized training in whatever issue I needed help with" (Sean, GM). According to one lesbian participant, "it really depends on what the problem is. If it were a pain management or school concern, then it would not matter what the gender or sexual orientation is" (Lori, L). Some lesbian participants wanted a therapist who is "empathetic and compassionate as well as someone who challenges the way I think " (Mira, L) or "open, communicative, supportive, non-judgmental, not in your face but will give you guidance" (Deanna, L). Some other lesbian participants wanted therapists who had experience with "alcoholism", "childhood sexual abuse", or "eating disorders".

Theme III: Experience and/or Comfort with Lesbians, Gays and Bisexuals. Another predominant theme was a concern for a therapist who had positive attitudes towards homosexuality and/or was experienced in working with lesbians, gay men and bisexuals. Some participants said that they would try to find out from friends if a particular therapist had experience with lesbians, gay men and bisexuals and/or were gay-positive. "The therapist must be recommended by friends...this would mean that s/he is informed on gay/lesbian issues" (Walter, GM). "I wouldn't know how to find a good therapist other than word of mouth from other people's opinion based on experience" (Russell, GM). According to some lesbian participants, a therapist's "reputation in the community" is most important because "gay

therapists can be bad too" (Lina, L). "I would never go to a complete stranger, even if the person was lesbian or gay...it would have to be a person I know in advance or has heard of in very flattering terms from other people" (Cheryl, L). In general, many participants were concerned with finding out if a therapist was gay-positive, "all I need is a person who knows about my orientation and feels positively towards it" (Bassem, GM).

Theme IV: Therapeutic Styles. Many participants also demonstrated preferences for particular therapeutic styles. Some participants wanted a therapist who focuses on feelings and works in a non-directive manner. "I want a humanistic, caring and supportive person" (Kevin, GM). "A friendly, relaxed, informed, compassionate, genuine person who wants to talk about my feelings" (Allen, GM). "My preference....is to have someone who is open and honest and will listen to my feelings and honor them" (Asad, GM). "She or he must be willing to tell me a little bit about themselves....she or he musn't [sic] be too objective" (Louis, GM). "I want someone who allows me the opportunity to grow without putting words in my mouth...someone who lets work be done in a gentle safe manner with no time pressures" (Sharda, L). Some participants were explicit in their desire for a therapist who "fosters self-evaluation and discovery" (Marc, GM). A gay male participant wrote:

> My greatest concern is that a therapist help me go where I need to go, rather than trying to impose an agenda...I do not need to have a therapist who will tell me what to do or give me advice, but to help guide me through a decision-making process. (Will, GM)

On the other hand, some other participants expressed preferences for therapists who are relatively more direct in their therapeutic style. In other words, some participants wanted a therapist who "focuses on solving problems...he must challenge me and provide insight" (Stuart, GM). "He must ask probing questions and just not sit there staring at me asking how I feel" (Dino, GM). "I don't want any Freudian stuff or hypnotism" (Tyler, GM). "I want

someone who listens well...problem-solving oriented...and not overly [sic]attached to my 're-living' my childhood (Janet, L).

Theme V: Therapist-Client Similarities (other than sexuality and gender). A relatively less prevalent theme in the participants' comments was a need for similarities between the therapist and client other than gender and sexual orientation. Some participants wanted a therapist who would share similar sociopolitical views, "s/he must love Camilia Paglia and be a left-winger but not a Christian" (Louis, GM). Another gay male participant claimed that:

> As a patient, my first concern when choosing a therapist would be their stand on gay lifestyles. Of course, asking them such a point-blank question would not yield the unbiased answer I desire, thus the question would have to be more broad-based and involve the therapist's stand on many different issues. (Arvin, GM)

According to one lesbian participant, "I want someone who has a feminist perspective and understands what it is like to live in a society that discriminates on a variety of bases" (Mira, L). In general, it is important for a therapist to make "comments indicating awareness of, understanding of, knowledge about feminist concerns, concerns of people of color, other disadvantaged individuals and groups" (Dave, GM). In addition to similar sociopolitical views, similarities in cultural/ethnic or religious background were preferred by some participants. "a therapist with a religious background would be a big plus" (James, GM). "I would like to have a therapist who either is of the same ethnic background as I am, or is highly empathetic to my position. Coming from a different culture/religion puts different constraints on my lifestyle and thinking as compared to a North American/European person" (Arvin, GM).

Theme VI: Practical Considerations. The least prevalent theme of comments regarding the participants' preferences in a therapist focused on practical considerations. Convenience, affordability and availability were important factors in choosing a therapist as well as location. "I'm not out of the closet and don't want people to know I'm going for therapy" (Glenn, GM).

Things a Progay Therapist Might Say

There was an assortment of ideas as to what a therapist might say that would be considered "progay". Table 18 summarizes the themes which are rank-ordered by prevalence

Theme I: Demonstrates Knowledge, Experience and Comfort. In general, a therapist could say or do many different things that could be considered to be "progay". According to most of the participants' comments, a therapist would have to demonstrate some knowledge and experience of issues that are unique to lesbians, gay men and bisexuals. This knowledge could range from "knowing the lingo" (George, GM) and "using it properly" (Shannon, L), to understanding the "relevant issues that concern our community" (George, GM), or "the heterosexist oppression that gays experience and struggle with" (Russell, GM). A progay therapist would "accept and appreciate the experience of a lesbian" (Bridget, L), or "demonstrate knowledge of the coming-out process" (Joanne, L). A therapist would have to be comfortable with gays, "demonstrate that s/he had worked with gays or had gay friends" (Tyler, GM) or "allude to previous experience with gays" (Shannon, L). One lesbian participant said, "I wouldn't necessarily expect my therapist to utter statements that are 'progay' but to be accepting of me" (Marie, L). A progay therapist would have to "advertise in gay publications" (Vince, GM) or "provide a list of places and organizations where you could go and meet people who are facing challenges similar to you" (Joe, GM) in order to "demonstrate familiarity with the lgb [sic] community" (Mary, L).

Theme II: Express Similar/Compatible Views on Gay, Lesbian, Bisexual Issues. To a lesser degree, some participants expressed a need for a therapist to express similar or compatible views on coming-out and other gay, lesbian and bisexual issues. Some participants felt that living "openly gay" is essential for personal happiness as well as political strength and they wanted a therapist's to share this attitude. For example, some participants

Table 18

Predominant Themes of Participants' Ideas of a "Progay" Therapist.

		Frequency
I.	Demonstrates knowledge, experience, and/or comfort with lesbians, gay men and bisexuals	36
II.	Expresses importance of coming-out and other lesbian, gay and bisexual issues	15
III.	Minimizes topic of sexuality and/or differences between homosexuals and heterosexuals	14
IV.	Demonstrates competence as a therapist (regardless of sexuality issues)	14

claimed that a progay therapist would have to believe that "living gay is the ultimate goal" (Nizar, GM). "The more a therapist encourage me to come out, the more I'd consider him or her to be progay" (Andrew, GM). A therapist who encourages a person to "become more active in the community" (Teresa, L) or "join groups, committees and sports teams and provides reading material" (Sarah, L) would be considered progay as well as a therapist who "empathizes with the alienation and oppression from the straight world" (Chantall, L).

However, some other participants felt that a progay therapist would have to respect the client's views on coming-out and other gay, lesbian and bisexual issues, regardless of their nature. For some participants, a progay therapist would "respect your own chosen path...to come out or not" (Larry, GM). According to this theme, a progay therapist might say,"I want you to know it is not my job to steer you toward being gay or not gay...but to support you in your journey whatever you feel, or decide, is right for you" (Will, GM). As one participant wrote:

> A therapist should be supportive and encouraging if the patient is considering to come out. Coming out, unprepared, as a last ditch effort to save a failing, conflicted relationship can not be a good thing...a progay therapist who puts coming-out on a higher priority than living honestly with oneself is in effect antigay (Peter, GM).

Theme III: Minimizes Sexuality. Participants also tended to believe that a progay therapist would minimize the differences between homosexuals and heterosexuals. "In my opinion, the only way a therapist could convey to his or her patients that they are progay is by treating the relationships in their patient's lives just as they would a straight relationship" (Arvin, GM). A therapist who "talks about homosexual relationships just like they were heterosexual ones" (Teresa, L) or "recognizes gay relationships as valid as straight ones" (Stephanie, L) would be considered progay. According to some other participants, a progay therapist would minimize the importance and/or relevance of a person's sexual orientation.

Therefore, a progay therapist would "acknowledge the [client's] issues as a result of being human, NOT gay" (Craig, GM), "not assume that my problems are automatically a result of my gayness (Chris, GM), or "just deal with the issue at hand and wouldn't even bring up sexual orientation if it wasn't important" (Dorothy, L). In summary, a progay therapist would "focus on your presenting problem and not your sexuality...s/he would focus on your accomplishments in life that are not associated with you sexuality" (Asad, GM).

Theme IV: Demonstrates General Competence. A relatively less common theme was that some participants felt a progay therapist did not have to express positive views towards homosexuality and/or experience in working with lesbians, gays or bisexuals. The therapist just had to be competent and proficient, regardless of his or her views on homosexuality. "It's not so much a 'progay' or 'antigay' stance that concerns me, but a willingness to listen, be open and respond based on what has been said" (Brent, GM). A progay therapist would also have to "show sensitivity and understanding of the issues in all their complexity" (Telva, L). A progay therapist would "respect my feelings and validate me, not in spite of, or because of my sexuality, but simply as a person who needed professional assistance" (Chris, GM), "make supportive statements recognizing the difficulties that I was experiencing" (Simone, L), or "listen attentively, respect my issues, offer insights and be open to all sorts of discussions" (Alana, L). One lesbian participant wrote:

> ...the positive approach would be to start from the point of the view of the client, not questioning his or her sexuality...I don't believe a therapist has to be gay, mine is not. He asks me questions about homosexuality all of the time, which means he's not against me but wants to know more to help me (Cheryl, L).

Things an Antigay Therapist Might Say

The participants also produced a variety of possible antigay comments that a therapist could make. Table 19 summarizes the five broad categories generated from the open-ended

comments.

Theme I: Making Heterosexist and Homophobic Comments. In general, the most predominant theme focused on overt homophobic comments as well as heterosexist suggestions that homosexuality was inherently difficult, inferior to heterosexuality and that heterosexuals are healthier and happier than gays, lesbians and bisexuals. "Aren't you worried about losing your family or friends?" (Gerry, GM); "being gay must be a problem in our society" (Tyler, GM); and "it must be hard to be happy if you are gay" (Joe, GM). According to this perspective, an antigay therapist believes that "being gay is a source of all sorts of difficulties" (Martin, GM), "you should expect instability with same-sex relationships" (Mohamed, GM), and "you can't have a loving relationship or satisfying family relations and you will be automatically ridiculed and hated by others" (Geoff, GM).

According to many participants, an antigay therapist is also a person who believes that everyone is born heterosexual and that some people, for whatever reasons, "choose" to become gay, lesbian or bisexual. "A therapist who implies that being gay is a 'chosen' lifestyle is antigay" (Asad, GM); "the word 'choose' offends me deeply" (Terry, GM); "choosing is problematic in my mind. I 'choose' to come-out, not to be gay" (Warren, GM); "implying that I must deliberate, think and make a decision [to be gay] tells me that a therapist won't be helpful" (Gerry, GM). "Statements about choosing one's sexuality indicates to me a lack of understanding ...I suppose one chooses how one will live, ie: openly, honestly, with integrity,or closeted, hidden, untrue to oneself in deception and denial" (Tammy, L). "I find using the word, 'choice' irritating, one doesn't decide to be gay on Tuesday and straight on Wednesday because it was too painful" (Rachel, L).

Some other participants also thought that a therapist is antigay if s/he believes that homosexuality is a "phase" or something that could change. For example, a gay person will

Table 19

Predominant Themes of Participants' Ideas of an "Antigay" Therapist

		Frequency
I.	Making heterosexist and/or homophobic comments	61
II.	Implying pathology and/or a need for a "cure"	38
III.	Expressing ignorance and/or dissimilar attitudes towards coming-out and other gay/lesbian issues	27
IV.	Avoiding or discounting the topic of homosexuality	19
V.	Focusing on sexuality inappropriately or excessively	11

be happier if he "lets it pass" (Dino, GM). "I had a therapist who asked me if I was sure of my sexual orientation. He knew that I had been in a relationship for over a year and I felt positive about my orientation...so why did he ask?" (Aron, GM). "I was told that if I wasn't sure [about my sexuality], then I would hate myself after having sexual relations with men" (Shawn, GM). "I had a therapist who kept on asking me how I knew I was gay since I had never had sex with a woman, he claimed that I had no idea as to whether it would be satisfying" (Scott, GM). According to some lesbian participants, an antigay therapist would probably ask questions such as, "How do you know you are gay? How long have you been sure?" (Dorothy, L). Other examples include: "Have you ever tried to see the opposite sex romantically?" (Jean, L); and "it's just a phase, you haven't found the right person yet" (Simone, L). In summary, an antigay therapist is one who "implies that gays should try out heterosexuality, just in case. Yet heteros [sic] don't have to" (Lucinda, L).

Another way in which a therapist could act negatively is when s/he uses stereotypes of gays, lesbians and bisexuals. "...people who attempt to group all relationships together (homosexual with heterosexual) is [sic] missing the mark because homosexual relationships have additional considerations that straight relationships don't have" (Lori, L). A therapist who refers to gays, lesbians and bisexuals as a group, a "single entity, using words like 'they'"(Chantall, L) or "those people" (Alana, L) would be considered antigay.

Theme II: Implying Pathology and/or a Need for a "Cure". A therapist would also be considered antigay if s/he believes that homosexuality was some form of maladjusted, pathological behaviour which should be "cured". "Any suggestion that a therapy goal is to change is antigay" (Chris, GM). Any form of encouragement to reject or avoid gay feelings was considered antigay as well as indicating that homosexuality is "wrong or shameful" (Arvid, GM). Other examples include: "stating an interest in changing one's sexuality because

it is 'sick' or 'sinful' is antigay" (Nizar, GM); "suggesting that it could be cured is 'sick' to me" (Louis, GM); "a therapist-in-training said that I could change with really hard work in about 5 years" (Philip, GM). As another gay male participant said, "I saw a male therapist...he said that there was no such thing as homosexuality, just 'scared heterosexuals'. He said that I should just ignore my 'longings' and overcome my problems" (Wilf, GM). According one lesbian participant, a therapist is antigay when s/he "implies that homosexuality is wrong, against 'God's way' and states that one is different from 'normal' and you should not act on it" (Amber, L); "tells you that you must change in order to be happier" (Katrina, L); or suggests for you to "have children, then things might be better" (Janet, L). One lesbian participant envisioned:

> ...this man [neutral attitude condition] looking at me and stating that the first session has gone well and he'd like to start seeing me on a weekly basis. About the 3rd session, he'll state that...the questions that I am having in my current relationship are caused by "deep-seated" problems. This is antigay. I've already accepted my sexual orientation and now I have someone saying it's a mental problem (Ava, L).

Other examples from Theme II includes therapists who want to know "what went wrong" during childhood or adolescence. "Do you have any negative feelings toward your same-sex parent? Were you ever molested?" (Scott, GM), "...was your father absent alot as a child?" (Luke, GM), and "...was your father absent or abusive?" (Janet, L).

Theme III: Expresses Ignorance and/or Dissimilar Attitudes Toward Lesbian, Gay and Bisexual Issues. A therapist who expresses "ignorance and insensitivity" (Walt, BM) or dissimilar attitudes towards various gay/lesbian issues was considered to be antigay as well as a therapist who demonstrates a "lack of awareness, empathy and understanding of lgb [sic] issues" (Mary, L). For example, a therapist who wishes to "explore staying in the closet as a viable option" (Dan, GM) would be considered antigay. Other dissimilar views on coming-out include: "keep your identity as a secret" (Vince, GM) and "living in the closet is somehow

better or less painful" (Chi Man, GM). According to lesbian participants, statements against coming-out include: "no one has to know that you are gay, you can be celibate" (Teresa, L), "you shouldn't come out at all, this is something you can work through" (Shannon, L), and "you shouldn't come out unless you know it's going to be safe" (Judy, L).

On the other hand, expressing interest in "forcing a person out of the closet" when s/he is not ready was considered antigay by some participants. For example, it was considered dangerous for a therapist to say, "you owe it to others to come out" (James, GM). Therefore, even "progay" therapists may act inappropriately as exemplified by one participant who had a gay male therapist who "thought that there was only ONE way to be gay...and it wasn't how I wanted to be gay" (Wilf, GM). In summary, some participants felt it was necessary for:

> the counselor to respect where the patient is...the therapist can't force his or her views or perspectives on coming out onto the patient...the patient might end up resenting him should things not go as predicted and promised by the counselor...the counselor should not be eager to offer a pat solution to a complex problem (Arvin, GM).

Theme IV: Avoiding and/or Discounting Homosexuality. Participants also felt that therapists who avoided or discounted the topic of homosexuality were acting in an antigay manner. A therapist who "appears uncomfortable discussing it" (Fred, GM) would be evaluated negatively as well as a therapist who displayed "body language that indicated that he was uncomfortable" (Roger, GM). Other examples include: "silence from a therapist may be potentially more harmful than any negative statement" (Bruce, GM) and "...a therapist who really doesn't say too much...it is hard to tell if the therapist is really understanding what is being said or is trying to hide something (homophobia)" (Lori,L). In addition to uncomfortable silence and body language, a therapist who "discounts" or "appears disinterested when I talk about my dates" would be considered antigay as well as a therapist who "brushes off or belittles the issues" (Alana, L). One gay male participant reported that "during the past

election, there was a candidate with a proposal that was antigay and the anxiety level in the community rose. My therapist dismissed it as neurotic behaviour" (Chris, GM). According to one lesbian participant:

> antigay therapists (or naive ones) may not pick up on important cues from their clients. These therapists may also avoid issues specifically related to sex or other important issues for lgb (internalized homophobia or oppression within a small community) (Romina, L).

Theme V: Excessive and/or Inappropriate Attention to Sexuality. Finally, a few participants believed that antigay sentiment could be expressed when a therapist focuses on sexual issues excessively or inappropriately. Examples include a therapist who "ignores the issues at hand and focuses on your homosexuality" (Orest, GM); "asks questions about "my sexual acts or what I do in bed" (Chris, GM); or "wants to know my sexual behaviour overtly" (Alana, L).

CHAPTER IV

DISCUSSION

Lesbians and gay men have a number of concerns, needs and preferences for mental health services. This chapter integrates the findings from the survey, experiment and open-ended comments while discussing what lesbians and gay men want from the mental health profession. This is followed by a discussion of the diverse array of therapy experiences reported by lesbians and gay men with comparisons to previous research. A number of limitations in the current study were evident even though it appears to be a relatively comprehensive assessment of the needs of lesbians and gay men and their reported therapy experiences with mental health services. These limitations are detailed as well as some unique contributions of the current study. Implications for psychotherapists are included in this discussion for their consideration as well as some ideas for future research on this issue.

First of all, the findings from the current study suggest that many lesbians and gay men have distinct preferences for particular kinds of therapists. In general, it appears that lesbians want to work with female therapists, regardless of their sexual orientation whereas gay men want a gay or lesbian therapist. These results corroborate the findings of the National Lesbian Health Care Survey which found that lesbians were more concerned with a therapist's gender than sexual orientation or ethnicity (Ryan & Bradford, 1993). When asked to choose a specific type of therapist from a number of alternatives, the results were more specific. The participants demonstrated a definite preference for a therapist of the same gender and sexual orientation. For example, lesbian participants tended to chose a lesbian therapist as their first preference. Many of these participants claimed that a therapist of the same gender and sexual orientation would have similar life experiences which would ensure understanding, empathy

and compassion. Some participants felt that time would be "wasted" if they had to teach a "straight" therapist the "lingo", norms and regulations of the lesbian and gay community.

Even though the majority of participants voiced interest in working with a therapist of the same gender and sexual orientation, there was a mixture of other important concerns. This is not surprising since the lesbian and gay community is incredibly diverse with the only real common thread being their sexual orientation. The participants' open-ended comments suggested a diverse array of concerns, problems, suspicions, hopes and desires for different kinds of therapists and therapist qualities. It is only by their written comments that one can appreciate the complexity of their concerns on this issue. One of the most predominant concerns expressed was the need for a competent and experienced therapist. This desire for mastery supports the findings by Moran (1992) who found that lesbians' evaluations of a therapist were influenced relatively more by a female therapist's experience level than her sexual orientation. To a lesser extent, participants also voiced interest in working with therapists who share a similar ethnic/cultural background or sociopolitical views. In summary, similarity and experience level appear to be preeminent factors for lesbians and gay men when looking for a therapist. It appears that lesbians and bisexual women want experienced female therapists whereas gay men want experienced gay male or lesbian therapists.

It goes without saying that lesbians and gay men want successful and positive services from their therapists. However, it appears that positive experiences involve more than just having a therapist with a particular gender and sexual orientation. For example, participants voiced a clear preference for therapists who can demonstrate knowledge, competence, experience and comfort with lesbians and gay men. It also appears that having a therapist who shares similar views on various lesbian/gay issues will create a positive therapy experience. Based on findings from the current study's experiment, lesbians' and gay men's evaluations of

therapists with unknown sexual orientation are dependent to some extent on the therapists expressed views on coming-out. In particular, lesbians and gay men will evaluate therapists more favourably if the therapists communicate that "coming-out can be a wonderful experience...and that it is important for personal growth" yet acknowledge that it may be "difficult at first". It appears that lesbians and gay men who agree with such comments on coming-out will feel relatively more comfortable in discussing issues pertaining to their sexuality and other personal matters. It also appears that under these circumstances, lesbians will be more comfortable in discussing the full range of life's issues, even those that have no direct connection with sexuality.

In summary, there are many factors which appear to be related to a positive therapy experience. These include a therapist who demonstrates experience and comfort with lesbians and gay men as well as a therapist who communicates views on various lesbian/gay issues that are compatible with a client's own attitudes. Positive therapeutic experiences also appear to be related to having a therapist who minimizes the differences between lesbians and gay men and heterosexuals as well as a therapist who minimizes the importance and/or relevance of a person's sexual orientation to the personal difficulties which s/he is bringing to therapy. On the other hand, a therapist who makes overt homophobic or subtle heterosexist comments will be experienced negatively by lesbians and gay men. A therapist who is ignorant of issues that are unique to lesbians and gay men or expresses incompatible views on such lesbian/gay issues will also be evaluated negatively. Participants also voiced concerns about therapists who avoid the topic of homosexuality, discount the importance of it, focus on it inappropriately or dwell on it excessively.

The participants in the current study provided a multitude of examples and situations in which a therapist would be perceived as being "progay" or "antigay". This information

provides us with a detailed picture of the unique concerns, hopes and needs that lesbians and gay men possess regarding the kind of treatment they want from mental health profession. Since we now have a conception of these needs, we can try to assess the extent to which they have been met by the mental health professions. This can be done by examining the participants' reported experiences with psychotherapy.

A considerable amount of information regarding the participants' previous experiences with therapy was gathered in the current study. The majority of lesbian and gay male participants reported some form of experience with mental health services (92.3% and 74.0%, respectively). This relatively high number of participants reporting psychotherapy experience is consistent with previous findings. Based on a review of relevant research, Rudolph (1988) concluded that gays, lesbians and bisexuals seek counselling anywhere from two to eight times more often than the general population. In 1987, 73% of 1,917 respondents to the National Lesbian Health Care Survey (Bradford & Ryan, 1993) reported some form of contact with mental health services whereas 77.5% of the lesbian respondents in a survey by Morgan (1992) indicated some form of therapy experience. These percentages are substantially higher than national rates for American women (13.84% according to the National Center for Health Statistics, 1974-75).

The number of Canadian lesbian participants with therapy experience also appears to be disproportionately higher than national rates of mental health care utilization. Only four percent of 10,715 Canadian women over the age of 15 surveyed in General Social Survey by Statistics Canada (1991) reported contact with a psychologist within the past year. This appears to be substantially lower than the 33.3% of Canadian lesbian respondents from the current survey who reported some form of contact with a psychologist since adolescence. Similar statistics were observed with gay male respondents. Only three percent of 10,266

Canadian male respondents over the age of 15 reported contact with a psychologist within the past year whereas 29.4% of the gay male respondents in the current study reported contact with a psychologist at some point in time since adolescence. In summary, it appears that lesbians and gay men receive relatively more psychotherapeutic services compared to the general population. However, these estimations may be artificially inflated since the current sample is probably not representative of the entire lesbian and gay community. It is more than likely that people with therapy experience were more attracted or interested in participating in the current study than people who had never been to a therapist. It was common for a few people to say that they were interested in the subject matter yet they were hesitant or not willing to participate, citing that they had no opinions or concerns since they lacked therapy experience. Nevertheless, these individuals were encouraged to participate and many of them took the questionnaire packages home.

Some traditional gender differences in health care utilization were also suggested by the results from the current study. For example, significantly more women reported therapy experience compared to male respondents. This probably reflects the traditional assumption that women are more inclined to seek professional assistance with personal problems because it is expected of them to do so. Male respondents also reported significantly less experiences with long-term therapy compared to female respondents. This supports another traditional assumption that males, on average, seek psychotherapy to "fix" problems whereas many women seek therapy for personal growth. The relatively high number of lesbian participants with therapy experience supports the theory that psychotherapy plays a role in many lesbians' lives (Girard & Collett, 1983; and Morgan, 1992; Morgan & Eliason, 1992). Morgan (1992) hypothesized that lesbians place a greater value on psychotherapy than non-lesbian women and that they have more positive attitudes toward counselling than non-lesbians. Based on

qualitative data gathered in semi-structured interviews, Morgan and Eliason (1992) found that lesbians sought counselling more often than non-lesbian women because oppression creates more stressors for lesbians, personal growth with psychotherapy is modeled and accepted by the lesbian community, lesbians tend to be more introspective because they have had more practice in facing difficult issues, and lesbians have fewer resources for social support compared to men and non-lesbian women. The results from the current study do not directly support Morgan's hypotheses because the participants were never asked why they sought counselling. Nevertheless, the personal experiences provided by many participants in the current study appear to support many of Morgan's hypotheses (see Appendix J).

The majority of participants with therapy experience reported that they had worked with "mainstream" mental health professionals such as psychologists, social workers and psychiatrists. Some participants felt that they were forced to choose a particular therapist on the basis of cost, availability and convenience. That is, many participants did not "shop around" for a therapist. Instead, they went to their college/university counselling centre for free services, worked with therapists who were affiliated with their employment benefits, or went to local mental health clinics. Even though the majority of participants reported experiences with "traditional" mental health services, 18.6% of them also reported working individually with a "psychotherapist" such as a physician, art therapist or "a good listener on e-mail". This suggests that there is a willingness in the gay and lesbian community to seek alternative methods of assistance in solving problems, alleviating distress and personal growth. This willingness to seek alternative methods of help was also suggested by the number of participants who reported experiences with nonprofessional support groups. Overall, 35.3% of the participants reported attending some form of peer-support group, including groups for coming-out, 12-step programmes for survivors of child abuse, adult children of alcoholics or

substance-abusers, spiritual/religious retreats and encounter/consciousness-raising groups. The number of lesbian respondents in the current study who reported experiences with nonprofessional therapeutic services is similar to the NLHCS which found that 36% of its respondents had some form of experience with nonprofessional mental health services. This involvement with such a wide variety of peer-support groups appears to support the view that marginalized or oppressed people such as lesbians and gay men tend to seek alternative methods of mental health services for personal growth (Girard & Collett, 1983). According to Rochlin (1982), involvement with "consciousness-raising" groups such as peer-support groups for coming-out and/or living gay in a straight world, are an integral part of the self-actualization of gay males and lesbians. It increases a person's awareness of the personal and social complexities of the gay experience which enables them to develop a healthier identity (Rochlin, 1982). Once again, however, the number of lesbians and gay men who reported experiences with nonprofessional support groups may not be an accurate estimation for the whole lesbian and gay community given the sample's questionable representativeness. A significant proportion of participants were recruited from community groups and organizations. It is reasonable to assume that this is sample of people who are more inclined to participate in all sorts of group activities, including peer-support groups.

Other important findings from this survey focused on the experiences of gay male, lesbian participants with therapists of different sexual orientations. First of all, a substantial proportion of lesbian participants with therapy experience (40.7%) reported that they had worked with a lesbian therapist whereas only about a quarter (22.5%) of the gay male respondents reported that they had worked with a gay male therapist. Even though there are increasing numbers of openly gay and lesbian therapists in our society (Garnets et al., 1991), the majority of lesbian and gay male participants in the current study reported experiences with

heterosexual therapists or they did not know their therapists' sexual orientation. It appears that not everyone has access to these increasing numbers of openly gay therapists. Even under circumstances where there is access to gay and lesbian therapists, it appears that not all lesbian or gay people are interested in having such therapists. As mentioned earlier, the participants' open-ended comments suggested that there were many other important factors in choosing a therapist, including a therapist's experience and comfort with lesbian and gay issues as well as general competence as a therapist and similarity in cultural background and/or sociopolitical views.

It is difficult to determine if working with heterosexual therapists or not knowing a therapist's sexual orientation is something that lesbians, gay men and bisexuals should be concerned about. The lesbian and gay male respondents in this study reported, on average, a "moderate" level of satisfaction with heterosexual therapists or therapist with unknown sexual orientation. Some participants reported better experiences with openly gay or lesbian therapists whereas others did not. Only lesbian participants reported significantly more satisfaction with lesbian, gay or bisexual therapists compared to heterosexual therapists or therapists with unknown sexual orientation. Therefore, it appears that a therapist's sexual orientation has the potential to influence at least lesbians' therapy experience. Given that 54.2% of the current study's lesbian respondents did not work with openly lesbian, gay or bisexual therapists, then it is reasonable to suggest that they may have benefitted from working with lesbian, gay or bisexual therapists.

The satisfaction with therapy reported in the current study differs, to some extent, from previous research. In 1978, Gambrill et al, (1984) found that a large sample of lesbian, gay and bisexual people in the San Francisco Bay area were generally dissatisfied with mental health services and concerned with heterosexual therapists' intentions and attitudes towards

homosexuals. From 1977 to 1979, 48% of the gay, lesbian and bisexual people surveyed in Seattle indicated that they had difficulty in finding "adequate" counselling services (Klein, 1986). In a review of the literature, Rudolph (1988) claimed that "up to 50% of gay clients have reported discontent with their professional counselling experiences, with an average rate of dissatisfaction of approximately 40%, a rate exceeding that usually reported by heterosexuals" (p. 165). In general, results from past research are more negative compared to the current study which found "moderate" levels of satisfaction with therapy. The "moderate" level of satisfaction with mental health services could be a reflection of better mental health services provided by professionals who are more tolerant, aware and understanding of various lesbian/gay issues. However, one should not necessarily conclude that lesbians and gay men are experiencing better mental health services compared to the 1970s and 80s. These satisfaction ratings are mean averages with relatively high standard deviations, suggesting that there is a great variation in the therapy experiences of gay male and lesbian participants.

Recent research continues to demonstrate that gay, lesbian and bisexual people are having negative experiences with the mental health profession (Garnets et al., 1991). Silker (1994) found that college-aged lesbians, gay men and bisexuals were generally dissatisfied with general health and mental health services at a mid-size university in Michigan. According to Moss (1995), a significant proportion of lesbian, gay male and bisexual respondents were unaware of their therapists' sexual orientation. The respondents who had worked with therapists of unknown sexual orientation tended to report relatively less satisfaction in therapy because they perceived their therapists to be more biased against lesbians, gay men and bisexuals. Respondents who perceived antigay bias also reported less comfort in discussing various personal issues. The findings from Moss (1995) corroborate many of the current study's findings. For example, the majority of participants in both studies

reported experiences with heterosexual therapists or therapists with unknown sexual orientation. Lesbians in both studies reported greater satisfaction with lesbian therapists than heterosexual therapists or therapists with unknown sexual orientation. The participants in the current study also reported that they would feel less comfortable in discussing personal issues with a hypothetical therapist who did not disclose his/her sexual orientation and made negative comments on coming-out. This is similar to Moss (1995) who found that lesbians, gay men and bisexuals were less satisfied with therapists who do not disclose their sexual identity and less comfortable in discussing personal issues. Such perceptions of antigay bias and feelings of discomfort are not conducive to a positive therapeutic relationship and successful outcome.

The written comments by the lesbian and gay male participants are indispensable in understanding the quality of their therapy experiences. Even though the mean satisfaction ratings suggest that lesbian and gay male participants were generally satisfied with their therapy experiences, their written comments suggest a vast diversity of experiences, ranging from overtly negative to positive (see Appendix J). Overall, the participants' open-ended comments suggest that not all therapists are good. Even though many respondents reported that their current or most recent therapy experience was satisfactory, some of them reported terrible experiences from the past. Moreover, what determines a positive therapy experience for one person can be totally different for another person. Some participants told stories of therapists who were blatantly homophobic or subtly heterosexist whereas other participants had therapists who were inappropriate or lacked essential knowledge of gay and lesbian issues. Nevertheless, many participants also reported positive experiences. Some therapy experiences were positive because the therapists were openly gay or lesbian. Other participants reported positive therapy experiences because they had a therapist who demonstrated comfort and experience with lesbian and gay issues or they had a therapist who expressed attitudes toward

lesbian/gay issues that were in agreement with their own. It is interesting to note that some participants reported positive therapy experiences that did not appear to be related to a therapist's gender, sexual orientation or experience with lesbian/gay issues. Instead, their therapy experiences were positive because their therapist was genuine, compassionate, accepting and empathetic.

Limitations and Contributions

The most obvious limitation in the current study is the limited representativeness of the sample selected from the lesbian and gay community. According to Buhrke et al., (1992), the representativeness of nearly all research samples of lesbians, gay men and bisexuals are limited to some extent which makes it difficult to generalize the findings to the whole community. The sample of lesbians and gay men recruited for the current study is also limited in its representativeness for various reasons. For example, the majority of participants were Caucasian, highly-educated, middle-class and experienced in psychotherapy. As a result, this study will probably "join the ranks of studies which focus on Caucasian, highly-educated, middle-class lesbians [gays and bisexuals]" (Morgan, 1992b, p. 49). A major source of sampling bias were the settings in which participants were recruited. A deliberate attempt was made to recruit participants outside of college and university settings since one of the major limitations of previous research has been the "sample of convenience" (lesbians, gay men and bisexuals from campus groups) (Buhrke et al., 1992). Even though the majority of participants were *not* from colleges of universities, the representativeness of the sample remains questionable. It may be that highly educated people are more attracted to, or appreciative of research. As a result, they may be more motivated to participate in research projects such as the current study and easier to recruit. This "education factor", which appears to be a chronic

problem with survey research, limited my chances in obtaining a "true" representative sample of the lesbian and gay community. Finally, only a few bisexual people participated in this study despite many attempts to recruit bisexual women and men. In general, the majority of bisexual participants were women who worked in academic settings who responded to the Internet advertisement. Obviously, this is not a representative sampling of the bisexual community. As a result, excluding the data from bisexual participants became one of the most significant limitations of the current study, like most of the research involving the lesbian, gay and bisexual community.

Generally speaking, the participants in the current study represent lesbians and gay men who are "out" and active in various community groups. Therefore, the findings can be applied to lesbians and gay men who are visible and open enough about their sexual orientation to attend community groups or subscribe to lesbian/gay newsletters (Rothblum, 1994). Since the majority of participants appear to be relatively comfortable with their sexual orientation, it is reasonable to assume that they share similar attitudes, feelings and concerns toward the mental health professions. If the current study's sample would have had more "invisible" lesbians and gay men, then there may have been more variation in how they reacted to the hypothetical therapy vignettes as well as in their concerns, preferences and experiences in therapy. Recruiting participants by posting advertisements on the Internet, however, was a novel and deliberate attempt to recruit participants who were not necessarily members of community groups or organizations. Therefore, it may have served as a means of recruiting people who were not as comfortable or "out" as other lesbians, gay men and bisexuals who belong to community groups. Post-hoc statistical comparisons, however, indicated that participants recruited from the Internet were not significantly different from participants recruited by other means in their ratings of comfort with their sexuality. A

possible difficulty with recruiting on the Internet is that it may create other form of sampling bias issues because not everyone has access to computers. Relying on the Internet for recruiting participants may have inadvertently reinforced the education/socioeconomic bias in sampling already discussed.

Another limitation of the current study was the hypothetical therapy vignette employed in the experiment. Using artificial scenarios as experimental manipulations in controlled social science research has been criticized for years because the results are inevitably used to explain complex social phenomena in the "real" world. Nevertheless, they continue to be used by many social scientists because they are convenient, expedient and practical. Some of the participants' open-ended comments demonstrated the concern about using artificial scenarios and generalizing the results to real life. "This [vignette] is too general. Anything that is antigay or progay could be said by a therapist..."(John, GM). "I'm uncomfortable with making such evaluations based on such little information (Mary, L). "One session is too short to see if a person is prejudicial" (Asad, GM). "I had difficulty with this situation because I would never go to a male therapist (Brenda, L).

Even though it is controversial to generalize results from controlled experiments to the real world, the current study's results suggest that the participants' reactions could be influenced by experimental manipulation to some extent. It is plausible that the participants' reactions would have been more volatile if the experiment would have used procedures that were more realistic and impactful. Other researchers have been able to use more sophisticated procedures such as videotaped therapy sessions. Therefore, caution has to be exercised when comparing the current study's results with previous experimental research that have utilized different procedures and materials. The results from experiments that use videotapes (Moran, 1992), audiotapes (Atkinson et al., 1981) and written scripts may be difficult to synthesize

because of the varied procedures employed.

A major contribution of the current study were the open-ended questions in the survey. Previous research on the psychotherapeutic experiences of lesbians, gay men and bisexuals have tended to rely on quantitative survey methodology which does not adequately describe the "richness and complexity" of this issue (Morgan & Eliason, 1992). Allowing the participants to describe their experience in their own words inevitably creates a more comprehensive picture with subtle hues, colours and contrasts that would have never have been illustrated by the results of paper and pencil questionnaires alone. In fact, the vast array of ideas expressed by the participants challenges the utility of using only descriptive and inferential statistics that are derived from artificial rating scales in understanding this complex issue.

Another contribution of the study were the efforts I made to involve the participants in various aspects of the study beyond providing data. For instance, lesbians and gay men from the Windsor community contributed to the development of the hypothetical therapy situation and the pool of 20 attitudes which were later tested in the pilot study by another group of lesbians and gay men from the Windsor community. Changes were made to the Participant Questionnaire based on comments from the pilot study participants. In the main study, participants were informed that their involvement was important because it could help to bring about important changes in the training of therapists and services provided by mental health professionals. The opportunity for written feedback was given to each participant and many community groups have expressed interest in a presentation of the results at future meetings. All of these actions were intended to facilitate an atmosphere of equality, empowerment and emancipation. The participants' enthusiastic reception to my requests for participation as well as the relatively high number of completed surveys and written feedback suggest that the

participants did not feel that they were being treated as passive providers of data for a researcher who was trying to earn a doctorate. The participants appeared to feel that they were active agents involved in a process that was trying to generate some positive social change.

Implications for Psychotherapy

The findings from the current study have numerous implications for the training and practise of psychotherapy. For example, more open lesbians and gay men need to be professionally trained as therapists. One method of increasing the visibility of lesbians and gay men within the mental health professions may be to actively recruit them into training programmes. However, the reality of such an "affirmative action" policy may be difficult given our current conservative political climate and recent negative attitudes towards such social policies. Changes are also needed within professional organizations to encourage and support more openness. It appears that there are still too many lesbian and gay male professionals who "hide in the closet" in order to secure their own professional development. Even though this is understandable and perhaps wise in some situations, many of these "closeted" professionals may be losing opportunities to help lesbians and gay men deal with their personal issues.

The findings from the current study also suggest that therapists-in-training need to obtain specialized education and training for working with lesbians and gay men. Countless struggles, concerns and triumphs were shared by the participants in the current study which appear to be unique to the experience of lesbians and gay men. These must be communicated to professionals who might work with lesbian or gay male individuals. Of course, this is not a new recommendation. There are a few training programmes that have implemented graduate courses, seminars or workshops that address this issue. Nevertheless, specialized education

and training still needs to be advocated because research findings continue to suggest that negative attitudes and detrimental treatment by mental health professionals exist. To my knowledge, the handful of courses and seminars offered in professional programmes are usually optional and exist only at schools where there are lesbian and gay faculty who have tenure and academic interest in this issue.

The findings from the current study also suggest that some clients want an open and frank discussion with their therapists on various lesbian/gay issues and other relevant social issues. It appears that the development of a positive, growth-oriented psychotherapeutic relationship relies to some extent on a therapist disclosing personal information about him/herself including his/her views on various lesbian/gay issues. However, some psychotherapists do not believe in self-disclosure because of their theoretical orientation. Nevertheless, a therapeutic style in which the therapist acts as an "expert" and is relatively opaque appears to contradict some of the needs expressed by lesbian and gay male participants in this study. On the other hand, psychotherapy is not necessarily doomed between a gay or lesbian client and a therapist who refuses to disclose personal information or a therapist who doesn't share the same views on the coming-out process. There are probably countless other factors that can "compensate" for this apparent problem. In fact, working through such a struggle could be a useful experience for personal growth. A few participants related stories in which they were able to struggle with such difficulties towards a healthy, rewarding resolution.

Another implication for psychotherapists originates from the participants' comments regarding their needs for "competent" therapists who are "genuine, empathetic, and good listeners". It appears that lesbians and gay men are like any other potential consumer of psychotherapeutic services in that they want competent, experienced and helpful therapists. A therapist needs to demonstrate basic therapeutic skills in listening, compassion, empathy and

acceptance. This supports the theory that therapeutic effectiveness is associated with "process variables" such as empathy, genuineness and unconditional positive regard (Rochlin, 1982). A therapist who excels in these basic therapeutic skills may be able to work with a gay or lesbian client even if they disagree on various pertinent lesbian/gay issues. This may be the "safest" means of ensuring qualified services for lesbians and gay men until specialized education and training become more common.

Directions for Future Research

The current study only "scratched the surface" while trying to examine the relationship between the mental health profession and the lesbian, gay and bisexual community. It has been argued that our society is beginning to tolerate or accept the "gay lifestyle" but only in certain circumstances or situations (Herek, 1993). Therefore, it is necessary to monitor the impact of these societal changes on the mental health services received by lesbians, gay men and bisexuals. Such continued investigation will only be productive, however, if researchers continue to employ innovative methods of scientific inquiry, involving both quantitative and qualitative methods. Our knowledge of this complex social issue can only develop if we move beyond paper and pencil questionnaires to in-depth, semi-structured interviews as well as more complex experimental designs and materials. The methods utilized in the current study suggested that information from rating scales was limited in its usefulness. The information from open-ended questions helped to elucidate and make sense out of "mean preference ratings" and "mean satisfaction ratings".

Our knowledge of the relationship between the lesbian, gay and bisexual community and the mental health profession will also develop if researchers continue to make a concerted effort to sample in ways that accurately reflect the lesbian, gay and bisexual community. Gay,

lesbian and bisexual researchers will have to be creative in their attempts to recruit people from "all walks of life". More gay men, lesbians and bisexuals are needed from rural settings as well as non-European cultural/ethnic backgrounds. Lesbians, gay men and bisexuals are also needed from various age groups as well as different education and socioeconomic levels. Related to this issue of diversity is the need for more participation from bisexuals. The unique experience of bisexuality needs to be acknowledged and addressed. Such an acknowledgement may encourage bisexuals to identify themselves and participate in research on various lesbian, gay and bisexual issues. In the current study, there were some comments and feedback from bisexual participants which suggested that they felt unsupported by the lesbian/gay community and that many lesbians and gays were "bi-phobic". This is obviously a political issue as well as a research one. However, many research questions emanate from this issue. For example, what are the special difficulties in accessing "bisexual positive" mental health services? To what extent does "gay/lesbian positive" psychotherapy fail and/or serve bisexuals?

Other possible research topics emerge from the current study's findings. For example, approximately 35% the participants reported experiences with non-professional, non-traditional mental health services. Is this a permanent move away from traditional services provided by social workers, psychologists and psychiatrists? Is this growth in non-professional services a reaction to a perception of insurmountable barriers in obtaining successful services from traditional, mainstream mental health professionals? What political, social and personal factors relate to the current interest in "grassroots", paraprofessional mental health services. What are the unique aspects of peer-support groups, drumming and healing circles, creative artistic therapies and e-mail correspondents that seem to be attracting increasing numbers of lesbians, bisexuals and gay men?

Another interesting research topic suggested by the data is the process of how a

therapeutic relationship develops, grows and ends between a client and therapist. Some participants reported that they struggled with a heterosexual therapist and/or a therapist who expressed ignorant or unacceptable views on various lesbian/gay/bisexual issues. Nevertheless, they persevered with therapy and worked through these difficulties to a positive therapeutic outcome. What factors relate to such a process? Under what conditions could such a situation be growth-oriented or problematic? Some participants reported that they enjoyed "teaching" their therapist about the lesbian, gay and bisexual community whereas others reported that they enjoyed helping their therapists "expand" their views. Perhaps these individuals were "empowered" by the therapeutic process of working with therapists who appeared to be relatively open about their feelings, opinions and attitudes.

There are many more directions of research which can help to improve the mental health services provided to gay men, lesbians and bisexuals. In recent years, there has been considerable interest in providing mental health services to lesbians, gay men and bisexuals that are specialized and catered to their unique struggles and concerns. Psychology sections of bookstores demonstrate the explosive growth of self-help books and manuals for professional development on this topic. However, the usefulness and value of this new field of psychotherapy will depend on continued scientific inquiry. Research can help to improve the mental health services provided to lesbians, gay men and bisexuals which are long overdue because everyone is entitled to be treated with respect and dignity.

APPENDIX A

ETHNIC BACKGROUNDS OF LESBIAN AND GAY MALE PARTICIPANTS

Table 20

Ethnic Backgrounds of Lesbian and Gay Male Participants

	Lesbians (N=65)		Gay Men (N=123)	
Background	#	%	#	%
European	58	89.2	111	90.2
African American	1	1.5	2	1.6
Aboriginal	2	3.1	2	1.6
Asian	1	1.5	6	4.9
Arabic	1	1.5	1	0.8
Hispanic	1	1.5	1	0.8
Carribean	1	1.5		

APPENDIX B

CONSTRUCTION AND PILOT TESTING OF THE THERAPY VIGNETTE

A vignette of an initial therapy session needed to be developed for the experiment. Five gay men and three lesbians assisted in developing a hypothetical scenario in which a person seeks therapy for the first time. The presenting problems included relationship difficulties and struggles in coming-out which are typical problems for many gay, lesbian and bisexual people. In the hypothetical situation, the person is unhappy and experiencing problems with a partner who wants to move in together. However, the person is afraid of his/her parents' reaction to them living together in a one-bedroom apartment. Six different therapy vignettes were needed for the experiment because of its 2 (therapist sex) X 3 (expressed attitude), factorial design. As a result, three sets of attitudes toward same-sex relationships and coming-out were needed for the experiment (positive, neutral and negative attitudes). In collaboration with the five gay men and three lesbians, 10 attitudes toward same-sex relationships and 10 attitudes toward coming-out were constructed, ranging from overtly positive to negative ones. The purpose of the pilot study was to identify the best possible examples of positive, neutral and negative attitudes towards coming-out and same-sex relationships from this list of 20 attitudes.

Participants

The pilot study participants were 10 lesbians and 10 gay men from the Windsor area. The participants were chosen purposely to approximate the types of participants needed in the main study. Twenty four questionnaires were distributed but only 20 were returned. This 83% participation rate was relatively high but not surprising since all of the participants were

known to the researcher. There were no selection criteria other than the participants had to be at least 19 years of age. Participation was voluntary and written consent was obtained.

The mean ages of the lesbian and gay male participants were 29.37 and 28.70, respectively (SD = 6.93 and 8.15, respectively). Eighty percent (80%) of the lesbian and gay male participants reported an annual income of less than 30,000 dollars which reflects the fact that 70% of the lesbians and 60% of the gay men were full-time students at a post-secondary institution. Eighty percent (80%) of the lesbian and gay male participants had (or were in the process of achieving) a postsecondary diploma or degree. The majority of lesbian and gay male participants were of European descent (90% and 80%, respectively). In terms of relationship status, 60% of the lesbian participants reported that there were living with their partners in a monogamous relationship whereas only 10% of the gay male participants reported similar circumstances. Sixty percent (60%) of the gay males reported that they were single and dating different people whereas only 30% of the lesbians were doing the same. A summary of participant demographics are in Table 19.

Table 21

Demographics of Pilot Study Participants (N = 10 lesbians and 10 gay men)

	% of sample	
	Lesbians	Gay Men
Income		
under $10,000	40	40
10,000 to 30,000	40	40
30,000 to 60,000	20	10
over 60,000	0	10
Education		
high school	20	20
college diploma	10	20
undergraduate degree	40	50
graduate/professional degree	30	10
Occupation		
full-time student	70	60
service industry	10	20
social services	10	10
professional	10	10
Relationship Status		
single, not dating	0	10
single, dating different people	30	60
monogamous but living apart	10	20
monogamous and living together	60	10

Materials

Pilot Study Questionnaire (PSQ). The hypothetical therapy session was written in first-person in order to maximize the reader's involvement with the hypothetical situation. In the instructions, the participants were encouraged to pay attention to what it would be like for them to experience this situation. The therapist in the story was either male or female. After the therapy situation, 20 attitudes that the therapist might express were presented. There were 10 attitudes towards same-sex relationships (4 positive, 2 neutral and 4 negative) and 10 attitudes towards coming out (4 positive, 2 neutral and 4 negative). In the PSQ, participants were asked to rate their perceptions of the 20 attitudes on 7-point, Likert-type scales (1=antigay, 4=neutral, 7=progay). Participants were also asked to rate how realistic the attitudes were on 7-point, Likert-type scales (1=Very Unrealistic, 7=Very Realistic). See Appendix B for the Pilot Study Questionnaire.

Participant Questionnaire (PQ). The purpose of the PQ was to obtain various demographic data such as gender, age, education, income, relationship status and sexual orientation. This is the same participant questionnaire that was used in the main study. A complete description of this questionnaire is in the Method section (Chapter II). See Appendix D for the Participant Questionnaire.

Procedure

All of the participants were contacted by phone and asked for their voluntary participation. The materials, including a cover letter and consent form as well as the PSQ, PQ and a debriefing statement, were mailed with a postage-paid return envelope. See Appendix E for the cover letter, Appendix F for the consent form and Appendix G for the debriefing statement. A counterbalanced design was used in assigning PSQs to participants. Five gay

male and five lesbian participants were given a PSQ with a female therapist and the 20 attitudes whereas five gay male and five lesbian participants were given a PSQ with a male therapist and the 20 attitudes. Reminder notices were sent to all participants two weeks after the initial package was sent. This brief letter asked the participant to take a few minutes and complete the questionnaire if they had not already done so and thanked them for their participation.

Results

Attitude Ratings. The mean ratings of the coming-out items are displayed in Table 20 whereas the mean ratings of the same-sex relationship items are in Table 21. The mean ratings were rank-ordered so that the positive, neutral and negative items could be identified. In terms of the coming-out items, item 17 received the highest mean rating (M = 6.85; SD = 0.37) whereas item 6 received the lowest mean rating (M = 1.45; SD = 0.61). Item 16 received a moderate mean rating of 3.75 (SD = 1.73) which approximates a neutral rating of 4.00. In terms of the same-sex relationship items, item 18 received the highest mean rating (M = 6.10; SD = 1.12) whereas item 13 received the lowest mean rating (M = 1.20; SD = 0.92). Item 8 received a moderate mean rating of 4.75 (SD = 1.77) which approximates a neutral rating of 4.00.

The relationships between the coming-out and same-sex relationship items had to be examined before they could be combined in a single vignette. Table 22 consists of the correlations between the mean ratings of the coming-out and same-sex relationship items. Generally speaking, there were only a few significant correlations between the two sets of attitudes. For instance, the correlation between the highest rated items of each set was not significant, r (19) = .17 (items 17 and 18; coming-out and same-sex relationships,

Table 22

Mean Ratings of Attitudes Towards Coming-Out (N = 20)

Item #	Attitude Rating Mean (SD)	Realistic Rating Mean (SD)
17	6.85 (0.37)	5.21 (1.23)
19	6.60 (0.68)	5.00 (1.11)
7	6.40 (0.82)	4.74 (1.15)
20	6.20 (1.01)	5.53 (0.96)
9	5.90 (0.97)	5.11 (0.99)
16	3.75 (1.73)	4.53 (1.68)
10	2.85 (1.81)	4.58 (1.17)
1	1.95 (0.61)	4.47 (1.12)
15	1.65 (0.81)	3.68 (1.16)
6	1.45 (0.61)	3.90 (1.56)

Note: higher scores reflect more positive ratings (1 = antigay; 7 = progay)

Table 23

Mean Ratings of Attitudes Towards Same-Sex Relationships (N = 20)

Item #	Attitude Rating Mean (SD)	Realistic Rating Mean (SD)
18	6.10 (1.12)	5.16 (0.90)
4	6.05 (0.95)	4.90 (1.29)
5	5.95 (1.36)	4.37 (1.07)
2	5.70 (1.03)	5.00 (1.00)
12	5.30 (1.13)	5.21 (1.18)
8	4.75 (1.77)	4.56 (1.47)
3	2.35 (0.93)	4.26 (1.66)
11	2.20 (1.01)	4.00 (1.37)
14	1.85 (0.99)	3.32 (1.20)
13	1.20 (0.92)	3.42 (1.26)

Note: higher scores reflect more positive ratings (1 = antigay; 7 = progay)

Table 24

Correlations between Ratings of Attitudes Toward Coming-Out (x-axis) and Ratings of Attitudes Toward Same-Sex Relationships (y-axis) (N=20)

	#17	#19	#7	#20	#9	#16	#10	#1	#15	#6
#18	.17	.33	.01	.22	.40	.26	-.07	-.07	-.02	-.15
#4	.02	-.30	.24	**.54***	**.52***	.01	.22	.23	.09	-.13
#5	-.23	-.19	-.03	.32	**.68^**	.16	.25	.06	.13	-.10
#2	-.27	-.33	.08	.06	.34	-.09	.28	.06	.06	-.36
#12	.12	.23	-.19	.22	**.46***	.26	.23	.02	.18	-.36
#8	-.30	-.09	-.22	-.09	-.26	-.14	.00	-.06	.05	.01
#3	-.30	**-.43***	-.12	-.08	-.08	-.01	.31	.13	.17	-.11
#11	-.34	-.26	-.36	-.26	.02	.27	.16	.10	.03	**.45***
#14	.23	-.22	.01	.24	.04	**.48***	**.57***	.08	.26	-.23
#13	.17	.24	-.32	.02	.15	.37	.09	.20	**.55***	.20

* $p < .05$, ^ $p < .001$

respectively). In fact, there were no significant correlations between the three highest rated coming-out items and the three highest rated same-sex relationship items (items 17, 19, 7 and items 18, 4, 5; coming-out and same-sex relationship, respectively). These non-significant correlations suggested that participants who rated items 17, 19 and 7 positively did not necessarily rate items 18, 4, and 5 in the same way (coming-out and same-sex relationship items, respectively).

The lack of significant relationships between the positive coming-out and the positive same-sex relationship items suggested that it would be improper to combine the two items in a single vignette. As a result, one set of attitudes had to be chosen for the main study's therapy vignette. The coming-out items were selected for the main study's therapy vignette for a number of reasons, including greater realism and consensus. Overall, the coming-out items tended to have higher ratings of realism, with the most positive coming-out item having a higher realism rating than the most positive same-sex relationship item ($\underline{M}$ = 5.21, $\underline{SD}$ = 1.23 and $\underline{M}$ = 5.16, $\underline{SD}$ = 0.90; items 17 and 18, respectively). The most negative coming-out item also had a higher realistic rating than the most negative same-sex relationship item ($\underline{M}$ = 3.90, $\underline{SD}$ = 1.56 and $\underline{M}$ = 3.42, $\underline{SD}$ = 1.26; items 6 and 13, respectively). There was a higher consensus in the ratings of the coming-out items compared to the same-sex relationship items, as indicated by the smaller standard deviations. This suggested that participants tended to agree more on which coming-out items were positive, neutral or negative as compared to the same-sex relationship items. The three coming-out items that were chosen for the main study's therapy vignette were as follows:

> **Positive:** Your therapist thinks that some wonderful things can happen when a person comes out to his/her family and heterosexual friends. S/he thinks that coming out can help a person live a more rewarding and happy life. Your therapist admits that this can be difficult at first but it is important for growth. S/he will be happy to work with you as you go through this important journey.
> (Item 17, $\underline{M}$ = 6.85, $\underline{SD}$ = 0.37)

Neutral: Your therapist thinks that coming out is important and thinks that this will be important to work on together. However, it will be important to remember that one has to be careful in selecting whom one tells because some people might react negatively.
(Item 16, $\underline{M}$ = 3.75, $\underline{SD}$ = 1.73)

Negative: Your therapist thinks that you will have to be totally sure of your sexual preference before you announce it to everyone. According to your therapist, choosing to be a homosexual has to be done intelligently, with careful deliberation. Your therapist thinks it would be disastrous if you choose to come out because of this relationship and then decide that this lifestyle is too difficult or painful.
(Item 6, $\underline{M}$ = 1.45, $\underline{SD}$ = 0.61).

APPENDIX C

PILOT STUDY QUESTIONNAIRE

Instructions: The following brief story requires you to imagine yourself in a particular situation. As you read this story, you might recognize that some of these issues are relevant to your personal life, or to people that you know. Your instructions are to read this story, imagine yourself in this situation, and complete the ratings that follow the story.

I would like you to imagine that you've decided to go for psychotherapy because of some difficulties that you have been experiencing lately. Imagine that you are in a relationship that is just over a year old and as far as you are concerned, it is rewarding and satisfying. However, your partner is beginning to talk about moving in together. Imagine that this prospect creates some apprehension for you because you do not feel ready for such a change.

Imagine that you have been living away from your parents for a couple of years. You are pretty sure that they know you are gay but you never really talk about it. You think that you have a pretty good relationship with your parents but you are not sure what might happen if you move in with your partner into a one-bedroom apartment. Your partner has been talking about this for over a month now. As a result of your ambivalence, you fear that your relationship is becoming strained. Imagine that you have never felt as strongly about someone before, but you don't feel ready to deal with these issues. Last week, there was a big argument about this problem and you begin to fear that your partner might want to end your relationship.

As a result of this situation, imagine that you have become somewhat frightened about what might happen if your relationship doesn't improve quickly. You don't know what to do.

Your first therapy appointment is with a therapist who appears to be about forty. During this first session, you spend most of your time talking about your recent struggles and feelings. Imagine that your therapist appears pleasant, listens attentively, but really doesn't say too much.

When your therapist asks for your goals in therapy, you state that you want to be happier. You think that you'll be happier if you can resolve your relationship problems. You also wonder if coming out to your parents might be a part of solving these relationship problems.

The following excerpts are different possible responses from your therapist about your desire to save your relationship and come out to your parents. Read the excerpts and make the following ratings.

---

1. Your therapist warns you not to make any careless decisions about coming out. Your therapist doesn't really know if coming out is such a good idea because it may wreck havoc in everyone's lives, just not your own. Your therapist thinks that it is going to be important to explore this area and that long-term psychotherapy would probably be helpful in trying to understand how your past childhood experiences have brought you to where you are today.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

2. Your therapist agrees that focusing on your relationship is an admirable goal. Your therapist can appreciate the difficulties that you are encountering because every intimate relationship encounters difficulties. Exploring these struggles will be important for your personal growth and happiness.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

3. Your therapist thinks that it probably isn't necessary to focus on your relationship with your lover right now. Your therapist thinks that whatever happens between you and your lover will happen inevitably. Instead, your therapist thinks that it will be more important to explore why you don't have a close and honest relationship with your parents.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

4. Your therapist acknowledges your desire to work on your relationship because it is very important to you. Your therapist looks forward to working with you on this issue.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

5. Your therapist thinks that it is fantastic that you have been in a relationship for over a year. Your success in your relationship is proof that long-term, same-sex relationships are important and more than possible. Your therapist looks forward to helping you explore your current struggles with your relationship in order for you to feel better about yourself and your relationship.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

6. Your therapist thinks that you will have to be totally sure of your sexual preference before you announce it to everyone. According to your therapist, choosing to be a homosexual has to be done intelligently, with careful deliberation. Your therapist thinks it would be disastrous if you choose to come out because of this relationship and then decide that this lifestyle is too difficult or painful.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

7. Your therapist thinks that coming out to your parents can be one of the most important events in a young adult's life. Whatever happens to you with your parents, your therapist will be available to help you go through this important journey.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

8. Your therapist thinks that it is quite possible to save your relationship. However, experiencing difficulties is something to be anticipated in any same-sex relationship, especially since our society is still homophobic and heterosexist.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

9. Your therapist acknowledges your desire to explore the process of coming out because it is vital to your self-esteem. Your therapist looks forward to working with you on this important issue.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

10. Your therapist thinks that therapy is warranted. Your therapist thinks that some issues need to be explored regarding coming out. For instance, your therapist wants to know how much you value your family. Your therapist thinks that family relations are the most rewarding source of love and joy. According to your therapist, jeopardizing family relations is self-destructive. Your therapist thinks that your decision to tell your family about your choice of sexual practices should be thoughtfully considered.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

11. According to your therapist, it sounds like you are trying to make this relationship into a long-term, monogomous relationship, much like it is between a husband and his wife. Your therapist understands how your difficulties in trying to aspire to this type of relationship is causing you considerable distress. Your therapist thinks that it will be necessary to focus on adjusting to your situation, and making more realistic goals for your future relationships.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

12. Your therapist agrees that moving in with your partner is a major step in your relationship and that it must be a challenging and scary prospect. Your therapist thinks that this is a common struggle for many people and that therapy aimed at exploring your fears of moving in will be very important.

How would you rate this therapist's attitude towards same-sex relatonships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

13. Your therapist says it is hard to say at this point whether you should try to save your relationship. Your therapist's experience with same-sex relationships has given your therapist the impression that they appear rewarding at first, but difficulties typically arise, leading to disillusionment and break-ups. Your therapist has had some success with gay clients who decided not to pursue them because they were able to accept the fact that long-term gay relationships are very difficult.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

14. Your therapist warns you not to make any rash decisions about moving in with your lover. Your therapist is worried about what people might think if you move in with your lover. It could destroy your relationships with your parents. Since your parents probably don't know about your sexual preference, then some "damage control" will have to be planned. It will be a real disaster if this happens, especially if your relationship with your lover ends too. Too many things are at risk if you move in with your lover right now.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

15. Your therapist thinks that coming out has to be done very slowly and cautiously, if at all. Your therapist sometimes wonders if it is a good idea because so much pain is typically involved. Your therapist thinks that coming out can only be done successfully if one has developed superior psychological defenses. Your therapist's opinion is that minimizing the pain can be done through intensive psychotherapy which takes considerable time.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

16. Your therapist thinks coming out is important and thinks that this will be important to work on together. However, it will be important to remember that one has to be careful in selecting whom one tells because some people might react negatively.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

17. Your therapist thinks that some wonderful things can happen when a person comes out to his/her family and heterosexual friends. Your therapist thinks that coming out can help a person live a more rewarding and happy life. Your therapist admits that this can be difficult at first but it is important for growth. Your therapist is happy to work with you as you go through this important journey.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

18. Your therapist thinks that it is more than possible to be in this relationship. Your therapist is happy to work with you on this issue because nothing is more wonderful than two people involved in a loving, healthy, committed relationship.

How would you rate this therapist's attitude towards same-sex relationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

19. Your therapist is happy to work with you on the issue of coming out. Your therapist's experience is that coming out can be a difficult process but it can lead to more rewarding and satisfying relationships with your parents. Your therapist thinks that people sometimes underestimate their parents' capacity to love, understand, and accept. Your therapist thinks that any short-term pain will be worth it in the long-run.

How would you rate this therapist's attitude towards coming-out?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

---

20. Your therapist agrees that your parents might have to deal with some difficult issues if you choose to move in with your partner. Your therapist can understand your ambivalence and fears since you have never really told your parents about yourself. Your therapist thinks that it will be a good idea to explore your fears about coming out to your parents and is happy to work with you on these important issues.

How would you rate this therapist's attitude towards same-sex realationships?

1	2	3	4	5	6	7
antigay			neutral			progay

How realistic is it that a therapist would make this kind of statement?

1	2	3	4	5	6	7
very unrealistic						very realistic

In your own words, what types of things might a therapist say about same-sex relationships and coming out that you would consider to be antigay or progay? Please include your personal experiences with psychotherapy and/or your knowledge of friends' experiences.

APPENDIX D

THERAPY VIGNETTE AND RATING FORM

Instructions: The following brief story requires you to imagine yourself in a particular situation. As you read this story, you might recognize that some of these issues are relevant to your personal life or to people that you know. Your instructions are to read this story, imagine yourself in this situation, and complete the ratings that follow the story.

I would like you to imagine that you've decided to go for psychotherapy because of some difficulties that you have been experiencing lately. Imagine that you are in a relationship that is just over a year old and as far as you are concerned, it is rewarding and satisfying. However, your partner is beginning to talk about moving in together. Imagine that this prospect creates some apprehension for you because you do not feel ready for such a change.

Imagine that you have been living away from your parents for a number of years. You are pretty sure that they know about your sexual orientation but you never really talk about it. You think that you have a pretty good relationship with your parents but you are not sure what might happen if you move in with your partner into a one-bedroom apartment. Your partner has been talking about this for over a month now. As a result of your ambivalence, you fear that your relationship is becoming strained. Imagine that you have never felt as strongly about someone before, but you don't feel ready to deal with these issues. Last week, there was a big argument about this problem and you begin to fear that your partner might want to end your relationship.

As a result of this situation, imagine that you have become somewhat frightened about what might happen if your relationship doesn't improve quickly. You don't know what to do.

Your first therapy appointment is with a **woman/man** who appears to be about forty. During this first session, you spend most of your time talking about your recent struggles and feelings. Imagine that **s/he** appears pleasant, listens attentively, but really doesn't say too much. When your therapist asks for your goals in therapy, you state that you want to be happier. You think that you'll be happier if you can resolve your relationship problems. You also wonder if coming out to your parents might be a part of solving these relationship problems.

Positive Attitude Condition:

Your therapist says that some wonderful things can happen when a person comes out to his or her family and heterosexual friends. **S/he** thinks that coming out might help you to live a more rewarding and happy life. **S/he** admits that this might be difficult at first but it will be important for your growth. **S/he** states that **s/he** will be happy to work with you as you go through this important journey.

Neutral Attitude Condition:

Your therapist agress that coming out is important. However, **s/he** thinks that you will have to be careful in selecting whom you tell because some people might react negatively.

Negative Attitude Condition:

Your therapist says that you will have to be totally sure about your sexual preference before you announce it to everyone. **S/he** thinks that choosing to be homosexual has to done intelligently, with careful deliberation. **S/he** thinks it would be disastrous if you choose to come out because of this relationship and then decide that this lifestyle is too difficult or painful.

THERAPIST RATING FORM

Please make the following ratings based on the therapy session that you just read. Remember, there are no right or wrong answers and your responses will be kept confidential and anonymous.

Counseling Concerns Scale

Instructions: Please indicate how comfortable you would feel in discussing the following personal concerns with this therapist. Choose a number from 1 = Very Uncomfortable to 5 = Very Comfortable:

Concerns	Comfort				
	Very Uncomfortable				Very Comfortable
1. Issues of career choice	1	2	3	4	5
2. Break up with a lover	1	2	3	4	5
3. Decision to come out to my parents	1	2	3	4	5
4. Roommate problems	1	2	3	4	5
5. My academic program	1	2	3	4	5
6. How I feel about my sexuality	1	2	3	4	5
7. Stressful issues of school or work overload	1	2	3	4	5
8. Coming out to my friends	1	2	3	4	5
9. Making job applications	1	2	3	4	5
10. Dating concerns	1	2	3	4	5
11. Health concerns (i.e.sexually transmitted diseases)	1	2	3	4	5
12. Issues of personal growth	1	2	3	4	5
13. Relationship with my family	1	2	3	4	5
14. Relationship with my lover	1	2	3	4	5

Counselor Rating Form

Instructions: Please evaluate this therapist on the following items. For example, choose a number from 1 to 7 where 1=Unfriendly and 7=Friendly for item #1:

1.	1 Unfriendly	2	3	4	5	6	7 Friendly
2.	1 Confidential	2	3	4	5	6	7 Revealing
3.	1 Unattractive	2	3	4	5	6	7 Attractive
4.	1 Honest	2	3	4	5	6	7 Dishonest
5.	1 Stupid	2	3	4	5	6	7 Intelligent

6.	1 Responsible	2	3	4	5	6	7 Irresponsible
7.	1 Unappreciative	2	3	4	5	6	7 Appreciative
8.	1 Vague	2	3	4	5	6	7 Clear
9.	1 Prepared	2	3	4	5	6	7 Unprepared
10.	1 Illogical	2	3	4	5	6	7 Logical
11.	1 Unreliable	2	3	4	5	6	7 Reliable
12.	1 Unskillful	2	3	4	5	6	7 Skillful
13.	1 Insightful	2	3	4	5	6	7 Insightless
14.	1 Deceitful	2	3	4	5	6	7 Straightforward
15.	1 Cheerful	2	3	4	5	6	7 Depressed
16.	1 Warm	2	3	4	5	6	7 Cold
17.	1 Likeable	2	3	4	5	6	7 Unlikeable
18.	1 Incompatible	2	3	4	5	6	7 Compatible
19.	1 Selfless	2	3	4	5	6	7 Selfish
20.	1 Sociable	2	3	4	5	6	7 Unsociable
21.	1 Informed	2	3	4	5	6	7 Ignorant
22.	1 Diffuse	2	3	4	5	6	7 Analytic

23.	1 Unalert	2	3	4	5	6	7 Alert
24.	1 Undependable	2	3	4	5	6	7 Dependable
25.	1 Disrespectful	2	3	4	5	6	7 Respectful
26.	1 Insincere	2	3	4	5	6	7 Sincere
27.	1 Closed	2	3	4	5	6	7 Open
28.	1 Close	2	3	4	5	6	7 Distant
29.	1 Expert	2	3	4	5	6	7 Inexpert
30.	1 Confident	2	3	4	5	6	7 Unsure
31.	1 Untrustworthy	2	3	4	5	6	7 Trustworthy
32.	1 Biased	2	3	4	5	6	7 Unbiased
33.	1 Inexperienced	2	3	4	5	6	7 Experienced
34.	1 Agreeable	2	3	4	5	6	7 Disagreeable
35.	1 Indifferent	2	3	4	5	6	7 Enthusiastic
36.	1 Formal	2	3	4	5	6	7 Casual

Based on your impressions, how **confident** are you that this therapist is gay, lesbian, or bisexual?

1	2	3	4	5	6	7
Not Confident						Confident

Based on your impressions, how **confident** are you that this therapist is heterosexual?

1	2	3	4	5	6	7
Not Confident						Confident

To what extent do you agree/disagree with this therapist's view that **(Positive, Neutral or Negative Attitude Towards Coming-Out)**

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

How realistic was this hypothetical therapy session?

1	2	3	4	5	6	7
Unrealistic						Realistic

How relevant were the issues in the hypothetical therapy session to your personal life?

1	2	3	4	5	6	7
Irrelevant						Relevant

In your own words, what types of things might a therapist say that you would consider to be antigay or progay? Please include your personal experiences with psychotherapy or your friends' experiences.

APPENDIX E

PARTICIPANT QUESTIONNAIRE

Instructions: Please answer the following questions as truthfully as possible. There are no right or wrong answers. Remember that your responses will be confidential and anonymous.

---

1. Are you male _____ or female _____?

2. What is your age? _____

3. What type of job do you have? (please describe your occupation if it is unique)

4. What is your annual income?

   [] under $10,000
   [] 10,000 to 30,000
   [] 30,000 to 60,000
   [] over 60,000

5. What level of education do you have?

   [] graduate/professional training (e.g., Ph.D., M.A., LL.B, M.D.)
   [] university graduate (e.g., B.A., B.Sc.)
   [] community college graduate (e.g., diploma)
   [] high school graduation (grade 12/13)
   [] partial high school
   [] junior high school (completed 7th, 8th, or 9th grade)
   [] less than 7 years of school

6. Are you a university or college student? _____ Yes _____ No

7. What is your ethnic/racial background?

8. What is your sexual orientation?

   [] gay [] lesbian [] bisexual [] heterosexual [] unsure

9. Briefly describe your relationship status:

   (e.g., I'm single and I date different people on a regular basis; I've been dating one person for 3 months; I've been living with someone in a monogomous relationship for 2 years)

10. Please indicate which of the following people that are aware of your sexual orientation: (mark as many as apply)

[] casual friends
[] close friends
[] co-workers/fellow students
[] employers/professors
[] neighbours
[] parents
[] siblings
[] relatives other than immediate family
[] clergy
[] roommates

11. Please estimate the percentage of people that you know well (e.g., friends, relatives, coworkers) who are aware of your sexual orientation (e.g., 75%, 50%, or 25%)

12. Have you ever had psychotherapy or counselling?

[] Yes [] No (If you answered no, please proceed to Question 14)

a) How many different therapy experiences have you had? (e.g., I have seen 2 different therapists for individual counselling; I have had group and individual counselling with the same therapist)

b) What type of therapist(s) have you had?
(mark as many that apply)

[] clinical psychologist [] social worker [] psychiatrist [] pastoral counsellor

[] other: _____

c) What type(s) of therapy or counselling have you experienced?

[] individual therapy [] couple counselling [] family therapy

[] group psychotherapy [] support group (please specify: _____

[] other: _____

d) For each therapy experience, how many months did you attend therapy and how many times per month did you go?

e) Please indicate your satisfaction with your most **recent** psychotherapy or counselling

1	2	3	4	5	6	7
Very Dissatisfied						Very Satisfied

f) If you have more than one therapy experience, please rate your satisfaction for each one

13. To your knowledge, have you ever had a **lesbian/gay/bisexual** therapist?

[] Yes (please specify: _____)

[] No

[] Don't Know

If yes, then indicate your satisfaction with this lesbian/gay/bisexual counsellor

1	2	3	4	5	6	7
Very Dissatisfied						Very Satisfied

14. Should you ever go for therapy in the future, what kind of therapist would you prefer? (please **rank order** your preferences if you choose more than one)

[] lesbian	[] bisexual female	[] heterosexual female
[] gay male	[] bisexual male	[] heterosexual male

15. To what extent would a therapist's **gender** matter to you?

1	2	3	4	5	6	7
Not At All						Very Much

16. To what extent would a therapist's **sexual orientation** matter to you?

1	2	3	4	5	6	7
Not At All						Very Much

* In your own words, explain your preferences in choosing a therapist (Use the back of the page)

APPENDIX F

LETTER OF INTRODUCTION

Dear

I am a doctoral student in the Clinical Psychology programme at the University of Windsor. As part of my degree, I am conducting a research project that is concerned with the attitudes of lesbians, gays, and bisexuals towards psychotherapy. The results from this research project will be important for lesbians, gays, and bisexuals as well as for mental health professionals. The results will help to inform and educate the mental health profession about the unique difficulties that we experience and will enhance the clinical training of therapists and counsellors.

I am interested in obtaining lesbian, gay and bisexual research participants from all "walks of life". As a result, I would like to know if people from your organization would be interested in participating.

If people agree to participate in this study, they will be asked to read a brief story of a therapy session and to imagine themselves in this situation. They will then complete a short questionnaire concerning the therapy session and provide some basic information about themselves. This will not take more than 10 to 15 minutes to complete. It is important to note that previous experience with therapy or counselling is ***not*** necessary for participating in this study.

This research project has been cleared by the Ethics Committee of the Department of Psychology at the University of Windsor. ***The confidentiality and anonymity of participants is taken seriously and will be assured.*** All of the responses will be held in strict confidence and will be identified only by an anonymous code number.

Your participation in this study is much appreciated and needed. Because I am a psychotherapist as well as a member of the gay community, I believe that this research will have a great impact for the lesbian and gay community as well as the mental health profession.

I will contact you by telephone in the next week in order to discuss my request for participation. You can contact me by writing to the Psychology Department or by phoning me at home (519) 254-5067 or 1-800-989-4854. My email is P69@server.uwindsor.ca. I will be happy to discuss any possible arrangements that we can make. I thank you in advance for your consideration and cooperation.

Yours sincerely,

Stuart Gibson, M.A.
Doctoral Candidate
Department of Psychology

APPENDIX G

COVER LETTER

Dear Participant,

I am a doctoral student in the Clinical Psychology programme at the University of Windsor. As part of my degree, I have to conduct a dissertation research project. My research project is concerned with the attitudes of lesbians, gays, and bisexuals towards psychotherapy. I am interested in your attitudes towards psychotherapy even though you may have never worked with a psychotherapist. The results from this research project will be important for lesbians, gays, and bisexuals as well as for mental health professionals. The results will help to inform and educate the mental health profession about the unique difficulties that we experience and will enhance the clinical training of therapists and counsellors.

I am interested in obtaining gay, lesbian, and bisexual research participants from all "walks of life". Previous experience with therapy or counselling is ***not*** necessary for participating in this study. If you agree to participate in this study, you will be asked to read a brief story of a therapy session and to imagine yourself in this situation. You will then complete a questionnaire concerning the therapy session and provide some basic information about yourself.

This research project has been cleared by the Ethics Committee of the Department of Psychology at the University of Windsor. ***The confidentiality and anonymity of your participation is taken seriously and is assured.*** All of your responses will be held in strict confidence and will be identified only by an anonymous code number. If you choose to participate, please read and sign the Participant Information and Consent Form and seal it in the attached postage-paid white envelope. Your anonymity will be assured if you return the questionnaires in the separate postage-paid brown envelope.

Your participation in this study is much appreciated and needed. Because I am a psychotherapist as well as a member of the gay community, I belief that this research will have a great impact for the lesbian and gay community as well as the mental health profession. I thank you in advance for your consideration and cooperation.

Yours sincerely,

Stuart Gibson, M.A.
Doctoral Candidate
Department of Psychology

(519) 254-5067
1-800-989-4854
email: P69@server.uwindsor.ca

APPENDIX H

CONSENT FORM

Participant Information and Consent Form

LESBIANS, GAYS, AND BISEXUALS
IN PSYCHOTHERAPY

This research is concerned with the experience of lesbians, gays, and bisexuals in psychotherapy. If you agree to participate in this study, you will be asked to read a brief story about a therapy session in which you are to imagine yourself in this situation. You will then complete a questionnaire concerning this hypothetical therapy session and provide some basic information about yourself. This study should not take more than 15 minutes to complete. Previous experience with psychotherapy or counseling is not required for participation.

Consent to Participate

I have read the above description and agree to participate in the research procedures outlined. I understand that my participation is voluntary and that I may withdraw from the study at any time, at my request. I understand that my responses will be used for research purposes only, held in strict confidence, and identified only by a code number.

I understand that I can contact Stuart Gibson, M.A. or Charlene Senn, Ph.D. if I have any questions or comments about this study. The address is: Department of Psychology, University of Windsor, 401 Sunset Avenue, Windsor, Ontario, Canada N9B 3P4. (519) 253-4232 ext. 2217

I am aware that this study has been cleared by the Ethics Committee of the Department of Psychology at the University of Windsor and I may register any questions or concerns which I might have about this research with Dr. G. Ron Frisch, C.Psych., Chair of the Ethics Committee, Department of Psychology, University of Windsor.

I am aware that a summary of the results of this research can be made available to me when the study is completed, at my request.

DATE: _____

NAME: _____

SIGNATURE: _____

APPENDIX I

DEBRIEFING

Thank you very much for participating in this study. The purpose of this study is to investigate how lesbians, gays and bisexuals experience therapy under different conditions. It was hypothesized that lesbians, gays, and bisexuals' comfort in discussing personal concerns and evaluations of a therapist would be influenced by a therapist's expressed attitudes towards coming out. Certain background characteristics of lesbian, gay, and bisexual participants were also hypothesized to influence their responses to the therapy story. For example, previous therapy experiences and personal comfort with one's sexuality.

I would like to remind you that your responses to all questions will be kept confidential and anonymous. If you wish to receive a brief summary of this study's results when it is completed, please fill out the Request Form and mail/give it to me. This request form will be kept separate from your questionnaire. Once again, your participation in this study is much appreciated. If you have any questions, please do not hesitate to ask me.

REQUEST FORM

Name: _____

Address: _____

_____

APPENDIX J

CORRELATION TABLES FROM MULTIPLE REGRESSION ANALYSES

Table 25

Intercorrelations between Variables Predicting Gay Male Participants' Evaluation of the Therapist's Attractiveness (Attract, N = 115)

Variable	Attract (DV)	a	b	c	d	e
a. Agreement with Attitude	.48					
b. Comfort with Sexuality	.03	-.10				
c. Therapy Experience	-.05	.10	.23			
d. Attitude	-.47	-.67	-.11	-.16		
e. Therapist Sex	.02	-.03	-.12	.13	-.01	
f. d x e	-.39	-.48	-.02	-.23	.74	-.64

Note. Higher Attract scores reflect higher evaluations of attractiveness
a. higher scores reflect higher levels of agreement with therapist
b. higher scores reflect higher levels of comfort with sexuality
c. 0=no therapy experience, 1=therapy experience
d. 1=positive attitude, 2=neutral attitude, 3=negative attitude
e. 0=female, 1=male

Table 26

Intercorrelations between Variables Predicting Gay Male Participants' Evaluation of the Therapist's Expertness (Expert, N = 117)

Variable	Expert (DV)	a	b	c	d	e
a. Agreement with Attitude	.59					
b. Comfort with Sexuality	-.02	-.08				
c. Therapy Experience	-.00	.09	.23			
d. Attitude	-.42	-.67	-.12	-.15		
e. Therapist Sex	-.09	-.03	-.11	.11	-.03	
f. d x e	-.29	-.47	-.03	-.21	.74	-.65

Note. Higher Expert scores reflect higher evaluations of expertness

Table 27

Intercorrelations between Variables Predicting Gay Male Participants' Evaluation of the Therapist's Trustworthiness (Trust, N = 114)

Variable	Trust (DV)	a	b	c	d	e
a. Agreement with Attitude	.58					
b. Comfort with Sexuality	.00	-.08				
c. Therapy Experience	-.02	.08	.25			
d. Attitude	-.41	-.67	-.11	-.16		
e. Therapist Sex	-.11	-.02	-.12	.14	-.04	
f. d x e	-.26	-.48	-.01	-.23	.74	-.65

Note. Higher Trust scores reflect higher evaluations of trustworthiness

Table 28

Intercorrelations between Variables Predicting Gay Male Participants' Comfort in Discussing Issues Central to their Sexuality (Avcen, N = 121)

Variable	Avcen (DV)	a	b	c	d	e
a. Agreement with Attitude	.42					
b. Comfort with Sexuality	.01	-.09				
c. Therapy Experience	-.01	.07	.23			
d. Attitude	-.32	-.66	-.12	-.15		
e. Therapist Sex	-.12	-.04	-.11	.14	.00	
f. d x e	-.16	-.46	-.03	-.23	.73	-.64

Note. Higher Avcen scores reflect higher comfort levels

Table 29

Intercorrelations between Variables Predicting Gay Male Participants' Comfort in Discussing Issues Peripheral to their Sexuality (Avper, N = 119)

Variable	Avper (DV)	a	b	c	d	e
a. Agreement with Attitude	.31					
b. Comfort with Sexuality	-.07	-.09				
c. Therapy Experience	.02	.08	.23			
d. Attitude	-.27	-.65	-.12	-.17		
e. Therapist Sex	-.09	-.03	-.11	.14	.00	
f. d x e	-.15	-.46	-.02	-.24	.73	-.64

Note. Higher Avper scores reflect higher comfort levels

Table 30

Intercorrelations between Variables Predicting Lesbian Participants' Evaluation of the Therapist's Attractiveness (Attract, N = 62)

Variable	Attract (DV)	a	b	c	d
a. Agreement with Attitude	.45				
b. Comfort with Sexuality	-.11	-.40			
c. Attitude	-.54	-.74	.31		
d. Therapist Sex	-.05	-.03	.10	.05	
e. c x d	-.39	-.52	.22	.72	-.61

Note. Higher Attract scores reflect higher evaluations of attractiveness

Table 31

Intercorrelations between Variables Predicting Lesbian Participants' Evaluation of the Therapist's Expertness (Expert, N = 62)

Variable	Expert (DV)	a	b	c	d
a. Agreement with Attitude	.55				
b. Comfort with Sexuality	-.12	-.40			
c. Attitude	-.46	-.74	.31		
d. Therapist Sex	.04	-.03	.10	.05	
e. c x d	-.36	-.52	.22	.72	-.60

Note. Higher Expert scores reflect higher evaluations of attractiveness

Table 32

Intercorrelations between Variables Predicting Lesbian Participants' Evaluation of the Therapist's Trustworthiness (Trust, N = 63)

Variable	Trust (DV)	a	b	c	d
a. Agreement with Attitude	.58				
b. Comfort with Sexuality	-.17	-.39			
c. Attitude	-.52	-.74	.29		
d. Therapist Sex	-.02	-.02	.11	.04	
e. c x d	-.36	-.52	.20	.72	-.62

Note. Higher Trust scores reflect higher evaluations of attractiveness

Table 33

Intercorrelations between Variables Predicting Lesbian Participants' Comfort in Discussing Issues Central to Sexuality (Avcen, N = 62)

Variable	Avcen (DV)	a	b	c	d
a. Agreement with Attitude	.63				
b. Comfort with Sexuality	-.28	-.39			
c. Attitude	-.65	-.76	.29		
d. Therapist Sex	-.16	-.03	.11	.02	
e. c x d	-.35	-.52	.20	.73	-.62

Note. Higher Avcen scores reflect higher comfort levels

Table 34

Intercorrelations between Variables Predicting Lesbian Participants' Comfort in Discussing Issues Peripheral to Sexuality (Avper, N = 63)

Variable	Avper (DV)	a	b	c	d
a. Agreement with Attitude	.43				
b. Comfort with Sexuality	-.27	-.39			
c. Attitude	-.36	-.74	.29		
d. Therapist Sex	-.03	-.02	.11	.04	
e. c x d	-.18	-.52	.20	.72	-.62

Note. Higher Avper scores reflect higher comfort levels

APPENDIX K

THERAPY EXPERIENCES

The following excerpts are all of the therapy experiences that the lesbian, gay male and bisexual female participants provided in their open-ended comments. These therapy experiences vary from positive to negative. Moreover, the perception of a negative or positive experience depends on the participant's personal attitudes, beliefs and feelings on a number of different issues. As a result, there are a number of different ways in which a particular therapy experience can be evaluated. The reported therapy experiences have been reported verbatim in order to capture this vast diversity of experience.

GM374 My first therapist helped me to express my feelings. My second, fell asleep during sessions. My third therapist talked me into thinking I could live as a heterosexual and my present therapist is gay-friendly and has been effective in helping me toward fulfilment of basic human needs. I think a gay therapist would possibly be more helpful in regard to insights particular to gay life.

GM395 My therapist recognized the validity and significance of my sexual feelings, fantasies and experiences even though he did not appear to share them. He was progay, not in specific words, but in the general recognition that it was alright for me to be what I am. His goal for me was that I take responsibility for the effect of my orientation and the choices I was struggling to make in regard to separating from my wife and coming out.

GM147 Its difficult to have a clear preference because my worst experience was with a gay male therapist and the best I've had is with a straight woman. When I asked for a gay therapist or one with experience, the organization told me that all of the therapists with their organization were competent to work with all kinds of people.

GM125 I pretty much lucked into finding my therapist -- I didn't do much research myself -- merely took the suggestion of a friend. I think the main reason I feel so comfortable with her is that she is a very non-threatening, accepting, understanding person. I think that through surveying her calm strength I found my own strength and a big healthy dose of self-importance. A big part of my need in therapy was to forgive myself for being gay - I've always been my own worst critic. By listening to me in her omni-forgiving way, my therapist helped me forgive myself and realize that (in her words) I felt really inferior probably because I was comparing my insides to everyone else's outsides. It doesn't work like that!

I think one of the biggest reasons I stayed with my therapist is her non-judgmental, accepting mode of discussion. .... I think the necessary qualifications are: accepting, calm, sense of humour, forgiving, caring, and understanding of gay issues and related problems.

Without saying much at all [coming-out], my therapist let me know that she feels strongly about freedom of expression in sexual orientation; she looked at me with an open accepting look on her face and occasionally made reference to some very close friends of hers who happen to be a male couple. I understand making references to her personal life could be construed bad form, but she did it in general terms and it really helped my "get a head" on her views - so I could be comfortable with her on our "journey".

GM266 I have had therapy myself and been asked: how did I know I was gay? Was I sure that this wasn't a phase? What would I do and how would I handle it if in 3 years I decided I wasn't gay? Did I understand how this upset my family and friends? Do I realize how much my choice would throw my family into upheaval? Was I prepared for the stressful often isolated and unhappy lifestyle many gay men admittedly say they live in? (Note: after 2 sessions, I found another therapist!)

GM142 I had a similar experience. I agreed to see a psychologist when I came out to my parents (I said, "whatever I can do to help you to understand and get through this!!") The snake didn't believe I was gay because, hell! I was 18 and hadn't had sex yet! And, if I didn't want to be gay, it would be a lot of hard work & wasn't guaranteed to be successful (although he claimed to have one success, who, darn it anyway, got divorced eventually, but due to reasons "completely unrelated to his sexual orientation!") I reported the dork to his provincial association. It took my parents a long time and a lot of senseless pain to get over the damage he did

GM327 Words or silences which suggest that my gay relationships and feelings are less valid than hetero [sic] one... Obviously any attempt to change my orientation - as my therapist did a few years ago - by suggesting that it was "inconvenient" to be gay - I found that very invalidating and insulting, not to say ridiculous, as if I could have flipped a switch and become straight! The therapist was Jewish and I countered that comment by using his logic and told him that he ought to become Christian since being a Jew had been highly inconvenient in our century. He had no answer to that.

GM411 A previous therapist (psychiatrist) expressed that she believed that I, as well as all homosexuals, chose to be gay. She believed this because there is no scientific proof that it is a genetic occurrence. She believed that there is evidence to support her belief of "choice". She was very vague about this "evidence". I felt this was extremely antigay and have since terminated my therapy with her. I am currently in the process of obtaining the services of a new therapist. His or her view of homosexuality will be a determining factor in my choosing that therapist. I expect my therapist to be supportive of my sexual orientation. He or she must believe that I am gay, because it was chosen <u>for</u> me by my genetic makeup.

GM170 I was in therapy for 2 years (my first therapy experience) with the goal of changing my sexual orientation. This antigay therapist had me engage in self-hypnosis during which I was to visualize my homosexuality as a "dark cloud getting farther and farther away on the horizon". He also had me visualize sexual experiences with women.

Needless to say, I failed miserably and saw myself as a "hopeless" case. This therapist claimed to have many "successes" in converting sexual orientation, stating that many of his former clients were married with children (as if that is evidence of one's sexual orientation!).

GM200 My first and most positive counselling experience was with a straight man. From the sessions with him, I realized that I am not inherently bad and that I am deserving of all of the love and joy which a straight person may enjoy. These sessions began a period of risk-taking and coming out to myself as well as others. I've taken some steps back since then but that counselling experience changed my life.

L415 The closest I've come to an "antigay" shrink was one who seemed to presume that my unhappiness necessarily stemmed from my partner's genital structure, that my love for her and anger with her were expressions of gender frustration.

L408 In order to proceed in an attempt to get a high security clearance, I was required to have an interview with a therapist and take a personality test (in which they discovered I was gay) the result was that I was "defensive" but otherwise fine. Well, duh! My job was on the line. I left before I heard whether I got the clearance.

L359 All of my psychotherapy experiences have been with males (all heterosexual I sense) and it was what was not said - non-verbal stuff - that led me to feel there was a distance, almost a feeling of distaste for me from one therapist and a warm acceptance of me from another. I think the non-verbal language emanated from me as well.

L401 I've only had really excellent experiences with both women and men who are both homosexual and heterosexual.

L292 I have seen one psychiatrist who put me on antidepressants and tried to straighten me out. I quit as soon as he said I should be in hospital, and one psychologist who showed me that I was in a emotionally abusive relationship and I could do better. I listened, built up my self-esteem and got rid of that relationship. Now I am 10 years into a relationship that gets better every year.

L340 My only psychotherapy experience has been very positive, but I was aware that the therapist worked well with lesbians from talking to other lesbians. Most friends I have talked to have had positive experiences as well. Perhaps this is so because I live in a small community where we can share information on therapists and know most of them.

L287 I once went to a therapist when I was having difficulty sleeping. This psychiatrist advocated that the root of my problem was my relationship with a same sex partner. Every session he would ask me how I was progressing in termination my relationship and basically did little else to get to the root of the problem. I never went back after 6 or 7 sessions. I am presently with an Adlerian therapist. although he is not gay, his very respectful of my choices and has been instrumental in helping me come to terms with my sexuality.

L293 Dr. %&^ told me I slept with women for comfort and acceptance of a mother figure (my mother constantly criticized me for my looks and weight).

L121 My experience with a social worker was a positive one. She helped me look at myself rather than exterior influences and finding myself. I was able to accept myself. Therefore, those who don't accept me, it's their loss. This includes family.

L127 I had one straight therapist who sounded like she thought I should go straight and quit seeing her. On the first visit, another straight therapist talked about lesbian couples being prone to merging. That was ok, she was just being matter of fact about it and she prefaced it with saying that each type of relationship has its unique difficulties. I've had too many therapists assume that they knew what I needed (like the one in your story), rather than commit to working with me on developing my own ability to know what I need.

L158 In my therapy, my counsellor can't always identify with what I am saying relating to my sexuality. I can't say that she is progay or antigay, just uninformed. A lot of times, I have to explain gay issues to her, she does the best with the knowledge she has. Because of this, it took a long time to trust her. There are some issues I don't discuss with her because she doesn't understand. For example, how hard it is to talk to people I work with about my life, because of my sexuality, or how I have to keep part of me a secret, and am untruthful with many people about exactly who I am and the anger I feel because of it.

L88 My therapist was very supportive and accepted the gay lifestyle as legitimate and helped me work through my relationship problem.

L131 A progay statement from a therapist in the past for me has been "you seem very comfortable with yourself" end of discussion about being gay, but I considered it an affirming statement about my own view (healthy) of myself as a lesbian.

L56 You should go to softball games and hang out to meet women (I am not a jock). This was from my own personal experience with a therapist. She was basing her advice on stereotypes of lesbians.

BF406 After a terrible initial therapy experience (with a counsellor who told me to 'forget about my sexuality' as it would 'go away' after I dealt with incest issues), I had much higher expectations when I went 'counsellor shopping' later in my life. When I interviewed my counsellor, I made it clear that I wanted a counsellor who accepted bisexuality/lesbian as a legitimate identity, had a feminist take on sexuality, incest and counselling in general. I also emphasized that while my sexuality is part of me and deserves respect, I was looking for a safe person who could deal with incest issues. My counsellor came out to me in this interview as a lesbian, feminist and a survivor, and I appreciated her honesty and professional respect for my concerns.

BF168 So far, all of my therapists have been female and tended toward heterosexist bias. My partner of 7 years is male and my therapists have not been particularly helpful or supportive in facilitating exploration of my bisexuality, let alone and coming out issues. Thus, I'd really like to work with a bisexual female therapist.

BF1 My therapist was a straight male. He was pleasant, but I would never have another male straight again. I didn't feel like he could relate to me or vs.vs...also, I would not go to a social worker again. I simply don't think they are as qualified as a clinical psychologist.

BF19 His or her sexual orientation is not an issue for me - rather her/his ability to listen, empathize, understand and help me make decisions in my life.

BF418 My own experience was with a heterosexual male psychologist who told me he thought I looked 'too feminine' to be a lesbian (I believed myself to be a lesbian at that time) He proceeded to give me a "written test" the results of which confirmed his belief. We discussed the results, which seemed to puzzle him, and I explained that the test questions made a lot of assumptions - ie., I responded to questions about men giving me compliments that I don't find insulting and I admitted enjoying male company. I pointed out that my responses to those questions did not necessarily indicate I wanted to sleep with men. He was taken aback and told me I might have a point. We parted on friendly terms - his concern for me was genuine - but we both acknowledged that he was not the best person to help me with my problems. I have never attempted consulting a therapist again.

I have had great success, however, with a bisexual support group I discovered. I feel comfortable hearing and discussing problems with people who share my interests and concerns. At least for me, this has been more important than professional training.

BF305 I came out to my mother (when I had been with a woman for about 2 years) I then brought my mom to my therapist a day later. My mom accused the therapist of forcing me to be lesbian because "she certainly looked lesbian" My therapist (at that time in graduate school) handled it pretty well and nurtured my mom by acknowledging her shock and feelings of being overwhelmed. She told my mom that many people are "letting it all hang out these days" unlike the days of old. I felt that she colluded with my mom in shaming me for coming out. I didn't see her much after that. I saw another therapist 8 months later upon breaking up with my lover. I haven't slept with another woman since then.

BF349 The worst experience I ever had is when my partner and I went to a gay male therapist thinking he would be more open minded. He told us not to have any more 'affairs' while in therapy. I told him I find monogamy not within my personal or ethical choice and that he had no right to demand it of us. We went to him a couple more times but felt too inhibited to talk freely about our sex lives. We are still together after 7 years and still non-monogamous. When I went to a long term individual therapist, I asked around. I told her upfront I was bi and non-monogamous and that I didn't want to 'fix' what worked for me. She agreed.

BF328 My first experience was progay. She was easy to talk to but I was having problems with my self-esteem so it was hard. My second experience was with a male in his 40s and he seemed to be more ambivalent and only wanting to be technical and was more concerned that I knew the health risks of being sexually active. I believe he was antigay but felt the need to be supportive of me anyhow. I didn't like seeing him so I stopped.

BF342 At this point, I would consider myself bisexual and I have been in therapy (but not with a gay or lesbian therapist) I have been lucky to have progay therapists. They don't privilege heterosexuality as a desirable "lifestyle", even though I could conceivably "go either way" They demonstrate that they know something about "gay issues" without seeming condescending or patronizing. They know that gay relationships have some uniquely satisfying qualities re - safety, emotional intimacy,

etc. - They hesitate to apply hetero. [sic] paradigms, even while recognizing some similarities. They recognize their own homophobia and perhaps the internalized homophobia of many glb [sic] people.

BF85 I had a therapist who did not know that an AIDS ribbon was red, in fact, he argued with me about it!

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